AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE
BOARD OF DIRECTORS

Meeting Date: February 29, 2012
Time: 2:30 PM
Location: 125 Worth Street, Room 532

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-January 26, 2012

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

INFORMATIONAL ITEMS:

1. Business Intelligence Analytics — **MR. CONTINO**
2. Electronic Medical Record (EMR) Vendor Selection Update — **DR. CAPPONI**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: January 26, 2012

ATTENDEES

COMMITTEE MEMBERS:

Michael A. Stocker, MD, Chairman
Alan D. Aviles
Josephine Bolus, RN

OTHER BOARD MEMBERS:

Thomas A. Farley, MD
Vincent Calamia, MD

HHC CENTRAL OFFICE STAFF:

Gary Belkin, Senior Director, Office of Behavioral Health
Donna Benjamin, Restructuring Project Management Officer
Deborah Cates, Chief of Staff, Board Affairs
Consuelo Dungca, RN, EdD, Senior Assistant Vice President, Clinical Affairs
Marisa Salamone-Greason, Assistant Vice President, Corporation Information Technology Services
Caroline Jacobs, Senior Vice President, Safety & Human Development
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Irene Kaufmann, Senior Assistant Vice President, Community Physician Services
Robert Kurtz, MD, Senior Clinical Advisor to Chief Medical Officer
Linda Landesman, Assistant Vice President, Office of Professional Services & Affiliations
Patricia Lockhart, Secretary to the Corporation
Ronald Low, MD, Senior Director, Office of Statistics and Data Analysis
Tamiru Mammo, Deputy Chief of Staff, Office of the President
Ana Marengo, Senior Vice President, Corporate Communication & Marketing
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
Susan Meehan, Assistant Vice President, Medical & Professional Affairs
John Morley, MD, Deputy Chief Medical Officer
Deidre Newton, Senior Counsel, Legal Affairs
Iva Perlman, Associate Director, Risk Management
Bert Robles, Senior Vice President, Information Technology/Corporate Chief Information Officer
Salvatore Russo, Esq., General Counsel, Legal Affairs
Aleksandra Sas-Shea, Associate Director, LEP
Steven Van Schultz, Director, Office of Internal Audits
Manasses Williams, Assistant Vice President, Affirmative Action/EEO
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer, Medical & Professional Affairs
Angela Zumaran, Director, Enterprise Service Desk, IT

FACILITY STAFF:

Machelle Allen, MD, Interim Medical Director, Bellevue Hospital Center
Chris Constantino, MD, Executive Director, Elmhurst Hospital Center
Edward Fishkin, MD, Medical Director, Woodhull Medical & Mental Health Center
Joan Gabriele, Chief Nurse Executive, Queens Hospital Center
Elizabeth Gerdts, Chief Nurse Executive, Jacobi Medical Center
John Maese, MD, Medical Director, Coney Island Hospital
George Proctor, Senior Vice President, Central & Northern Brooklyn Network
Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc.
Denise Soares, Executive Director, Harlem Hospital Center
Ann Sullivan, MD, Senior Vice President, Queens Health Network
Arthur Wagner, Senior Vice President, Southern Brooklyn/SI Network
William Walsh, Senior Vice President, North Bronx Healthcare Network
Roslyn Weinstein, Executive Director, Kings County Hospital Center
Julius Wool, Executive Director, Queens Hospital Center

OTHERS PRESENT:

Melissa Dubowski, Analyst, Office of Management and Budget
Scott Hill, Account Executive, QuadraMed Corp.
Richard McIntyre, Key Account Executive, Siemens
Megan Meagher, Analyst, Office of Management & Budget
Anne Mitchell, CIR-SEIU
Claudia Prentice, Area Corporate Accounts, Siemens Medical Solutions

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE Thursday, January 26, 2012

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 2:36 P.M. The minutes of the December 15, 2011 Medical & Professional Affairs/IT Committee meeting were adopted. Dr. Stocker introduced the newly appointed Board member, Vincent Calamia, MD, and provided a short bio.

CHIEF MEDICAL OFFICER REPORT:

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

1. Employee Flu Campaign

Dr. Wilson noted that our performance on employee vaccination this year has been moderately disappointing and well short of targets compounded by a number of reasons. One of which was the absence of an obvious flu season early on but certainly compounded by the continued lack of any type of mandate around employee vaccination. One of the strategies we undertook to try to influence employees to get vaccinated was an incentive program, in which an Amazon Kindle Fire was awarded to one employee per HHC facility. Each employee who was vaccinated was entered into the Employee Vaccination Registry were eligible for the random drawing. A total of 25 employees were selected as winners of a new Amazon Kindle Fire. Dr. Wilson provided the Committee with a PowerPoint presentation showing the pictures of the contest winners.

Dr. Stocker asked what the current employee vaccination rate is. Dr. Wilson stated that it is under 50% which is a significant deterioration over the prior two years rate. The HHC Flu Task Force unanimously feel that a mandate is the only way, is important, and is a reasonable position to take from both a social and clinical perspective. The barriers to getting this mandate are significant but the Task Force has talked significantly about what we are able to do in terms of making flu vaccination a requirement of new employee's and working with the various Stakeholder's who have concerns about mandated vaccination. Other States in this country, several countries in the world are discussing and or implementing mandate vaccination policies. There are various organizations that have mandated flu vaccination as a requirement of employment. There have been four to six court cases in different States other than New York State, where employers have been taken to court by interest groups who oppose the requirement - on each of those occasions the employer won. Dr. Wilson noted that New York State withdrew the mandate for two reasons, one due to the opposition by various groups, but mainly due to the concern of insufficient vaccine supplies. Dr, Stocker inquired as to what was our highest vaccination rate. Dr. Wilson responded that in the past five years, our highest vaccination rate was close to 70%, with some of the D&TCs over 90%. Dr. Wilson noted that a rate of 85% is required in order to get to a significant effect on health outcomes for patients and staff.

2. CMS Health Care Innovation Challenge

The CMS Health Care Innovation Challenge is an opportunity to be funded for innovative new models of care delivery that fulfill the triple aim of "*better care, better health and lower costs"*. One billion dollars is available for three year projects, each of $1-30 million, with a minimum amount of $1 million allocation and a maximum amount of $30 million. HHC submitted a letter of intent, along with 53,000 other organizations. HHC will be submitting its application tomorrow, January 27th.

3. Regional Perinatal Centers (RPC)

The RPC team continues to conduct site visits at the affiliate perinatal centers to review cases and assist the facilities with developing plans for quality improvement related to direct services (OB and Neonatal) provided. To meet the educational needs of the perinatal staff, a perinatal conference hosted by Woodhull Medical & Mental Health Center was conducted on November 2, 2011. One hundred and sixty three (163) staff (physicians, certified nurse midwives, registered nurses, physician assistants and others) attended. Agenda topics included: Appealing to Ethical Principle of Respect for Maternal Autonomy; Labor and Birth Physiology: What Works Best and First Trimester down Screening.

4. Sexual Assault Response Teams (SART)

The SART program is funded through to June 30, 2012. The Criminal Justice Center (CJC) is preparing a new need request to have SART funded by the Mayor's Office with HHC to allow continue this very important initiative. In the 3rd Qtr'2011 (July – Sept) SART responded to 243 cases of rape/sexual assault in the boroughs of Bronx, Brooklyn, Queens and Manhattan.

Brooklyn Borough SART program includes Kings County Hospital Center, Woodhull Medical & Mental Health Center and Coney Island Hospital. Of the four HHC borough SART programs, Brooklyn continues to have the largest number of SART cases (85) and Bronx SART the second highest (66). The program is highly recognized by the DA's office for the quality of care provided and response time to rape/sexual assault victims within 60 minutes upon the victim's arrival at any HHC Emergency Department (ED). However, the program has a serious shortage of SAFE examiners and has to rely mostly on the SART program coordinator and 3 other SAFE examiners to fulfill the on-call needs of the program. NYC DOH SAFE protocol/ standard require that a SAFE examiner respond to the ED within an hour of the victim's arrival. Brooklyn SART is challenged with maintaining available number of SAFE examiners to cover 24/7 due to attrition rate; Central office staff has been assisting KCHC ED Medical Director and SART coordinator develop alternative plans to ensure SART examiner is available for rape victim to be seen by a trained SAFE examiner.

Clinical Affairs in collaboration with Rutgers, The State University will conduct a 40 hour SAFE examiner training course in March 2012 to continuously replenish the number of SAFE available to maintain the SART program. The 40 hour SAFE examiner training program, funded by the SART program is offered every two years.

5. Prevention of Alcohol Exposed Pregnancies (AEP)

The AEP is a grant funded program with the ultimate goal of reducing birth defects caused by fetal exposure to alcohol. The program is implemented at North Central Bronx Hospital, Harlem Hospital Center and Kings County Hospital Center Family Planning Clinics with trained AEP staffs who conduct alcohol screening through Motivational Interviewing technique, provision of appropriate education and counseling to patients qualifying for the program called CHOICES. CHOICES is a counseling intervention, that includes birth control consultation program offered to women at risk for an alcohol exposed pregnancy; and not meant to diagnose alcoholism, to label or stigmatize women.

6. Hurricane Irene - Federal Emergency Management Agency (FEMA) Application

The HHC Office of Emergency Management submitted a Corporate Application totaling approximately $4 million to FEMA to obtain reimbursement expenses incurred for hurricane Irene. Expenses include

mitigation, overtime staff, supplies, equipment for all HHC facilities and for the Special Medical Needs Shelters.

METROPLUS HEALTH PLAN, INC.

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee. MetroPlus from the New York City (City) perspective was rated as the number one health plan for five years out of the last six years and has been the top scoring City plan in the overall New York State wide (State) results. Two days ago, MetroPlus was informed that they are the highest scoring plan in the entire State for three overall groups of indicators. What this means is MetroPlus were only plan in the State to get the maximum quality bonus, a bonus above our per member per month of 2.5%. The first group of indicators was quality measures in which MetroPlus achieved a 100% score. The second group was customer satisfaction which they did pretty well, and the third group of indicators is quality indicators for admissions, medically necessary admissions for things that could be preventable - last year MetroPlus scored zero, this year they scored 50%. The indicator in this group that MetroPlus did not perform well in was asthma admissions. Overall from the State perspective, out of 150 points, MetroPlus obtained 126.5 points versus other plans that obtained 50-60 points. What does this mean? Depending on total member months and total revenue, MetroPlus will probably get a $35 million incentive bonus above the State base line rate and will invest this back into pay-for-performance and quality incentive programs for the providers.

Dr. Farley congratulated MetroPlus and inquired as to whether he can obtain the scores that Dr. Saperstein noted. Dr. Saperstein stated that he would provide the statistics but further stated the reason why we score so well is due to our providers with HHC, quality wise and more importantly the cooperation and alignment with same type of indicators, collecting the data etc.

Dr. Saperstein informed the Committee that the total plan enrollment as of January 1, 2012 was 423,300. Breakdown of plan enrollment by line of business is as follows:

Medicaid	354,683
Child Health Plus	18,234
Family Health Plus	35,910
MetroPlus Gold	3,190
Partnership in Care (HIV/SNP)	5,648
Medicare	5,635

During the period of January 1, 2011 to January 1, 2012, the Plan achieved a 3.85% membership growth, reaching over 423,000 members.

Dr. Saperstein provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans. In addition, he provided a graph showing net transfers for the month of December 2011 for Medicaid and Family Health Plus (FHP).

Dr. Saperstein informed the Committee that a number of enhanced initiatives have been put in place by MetroPlus's Medicare Marketing team and the MetroPlus Communications Department to enhance Medicare enrollment which include:

- Improve the referral relationships with key providers so that they will refer potentially interested members to our marketing team. A focused provider education campaign is currently underway;

- Establish a partnership with key City agencies and CBOs delivering services to our target population, with the goal of enhancing our community outreach efforts and increasing our presence in the community;
- Develop a member-centered media campaign targeting prospective members and care givers and/or opinion leaders within our target population through channels such as outdoors media (including subway), newspapers, and radio.

Dr. Saperstein informed the Committee that MetroPlus is working very closely with HHC to implement the HHC-MetroPlus Health Home. The program implementation is currently postponed to February 1st due to a delay in the New York State Plan Amendment being approved by CMS.

Dr. Saperstein updated the Committee on the status of CVS Caremark which became MetroPlus' Pharmacy Benefit Manager for our Medicare, Child Health Plus (CHP) and MetroPlus Gold members as of January 1, 2012. Now all of the Plan's 421,000 members are covered under CVS Caremark.

Dr. Saperstein informed the Committee that the New York State Department of Health announced that dental services are also being mandatorily carved into Medicaid Managed Care on July 1, 2012. MetroPlus currently provides dental services to its members in the FHP, CHP and Medicare lines of business (about 60,000 members) and expects to begin providing services to its Medicaid population (about 350,000 members) effective July 1, 2012. MetroPlus must secure a vendor and implement these services by April 1, 2012 to allow ample notification time to members. The MetroPlus released a pre-qualification form for its Negotiated Acquisition on December 16, 2011 and the two vendors who have pre-qualified are Healthplex and DentaQuest. DentaQuest is currently our vendor for the FHP, CHP and Medicare lines of business. MetroPlus' goal is to choose a vendor by the end of February 2012.

Dr. Saperstein informed the Committee that over the past eighteen months, MetroPlus has been involved in a Negotiated Acquisition for its core information system. MetroPlus has been with their current core system vendor, DST Health Solutions for the past 15 years. Through the negotiated acquisition process, MetroPlus narrowed their choices to two vendors, their current vendor and Trizetto Facets. The goal of their negotiated acquisition process was to ensure that they had the appropriate system and vendor to allow them to be successful, considering all of the known and unknown future changes and requirements. The contract would be for approximately five to six million dollars annually, with an implementation cost of 30-60 million dollars (based on information acquired during multiple site visits to other health plans). Based on internal and external assessments of their current staffing level and business practices, they decided that at this point, MetroPlus is not ready to make that significant level of change. Mostly, that decision was based on a potential failure of implementation if all the resources were not prepared before an implementation. Therefore, they will be closing the negotiated acquisition without making a final decision. Rather, they will use the next one to two years, to fully prepare their staff for the potential of a new system and then reopen their decision making process.

CHIEF INFORMATION OFFICER REPORT:

Bert Robles, Chief Information Officer reported on the following activities:

1. IT Governance Update

A year ago, Mr. Robles reported to this Committee on the restructuring of the IT Governance process and the creation of the IT Executive and IT Portfolio Management Committees. Both these committees are comprised of Executive and Senior Leadership across the Corporation and are charged with decision making

authority and accountability with regards to IT investments. Mr. Robles provided a brief update on the status of each committee's work in the past 12 months as follows.

The IT Portfolio Management Committee's (ITPMC) focus this past year has been to balance HHC's overall IT needs and priorities. The membership is comprised of operational leadership from the networks and Health & Home Care. The committee meets monthly and their charge has been to identify clinical and business issues requiring IT solutions, monitor those IT investments already underway and providing recommendations to the IT Executive Committee. They have been diligent in reviewing and validating project requests from the networks, asking the right questions and making the hard decisions of what gets funded or not. Committee members take their charge seriously and the group has coalesced into a governing body who's mandate is an "Enterprise first perspective" instead of a "Network first perspective" when reviewing IT project requests.

The IT Executive Committee meets bi-monthly and its membership is made up of all the Senior Vice Presidents including our Executive Vice President and President. This committee's charge is to establish IT strategies and policies approve project investments and provide the necessary balance for multiple stakeholder needs. Over the past year, this committee has concentrated their energies in fully reviewing and supporting both those critical IT project investments underway as well as the key IT strategic initiatives moving forward. Committee members continuously assess and question information provided to them in order to make the most effect IT decisions. This committee remains focused on ensuring that IT decisions support HHC's business strategy.

This year will be critical for both committees as IT pushes forward initiatives such as the new Enterprise Medical Record, Meaningful Use, Business Intelligence, RHIOs and Patient Centered Medical Homes (PCMH).

2. Windows 7 Project Update

Enterprise Information Technology Services (EITS) has put together a plan to upgrade the Corporation's Microsoft Operating System from Windows XP to Windows 7 as well as upgrade HHC's current office suite to Office 2010. Presently, HHC has an inventory of approximately 34,000 computer workstations, including mobile laptops.

Workstation refreshes and Operating System (OS) upgrade projects are typically among the most complex, demanding, challenging, expensive and potentially disruptive IT projects. However delayed adoption can cost the HHC money due to increased support requests, workstation management costs, ineffective security measures and other related IT issues.

EITS has spent the greater part of last year putting together a comprehensive plan which will include standardizing the desktop and training the workforce on Windows 7 and Office 2010. This project is scheduled to start in March 2012 and we anticipate finishing in June 2013. EITS provide a comprehensive presentation to the committee members on this project at the April M&PA/IT Committee meeting.

INFORMATION ITEMS:

1. Women's Health Measures

Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer presented the following women's health measures to the Committee.

- Percentage change in the number of deliveries in HHC between 2005 and 2010 per facility. Over that time the number of deliveries increased by 1,200 or 8% Corporate-wide.
- C-sections are a clinical and social discussion – what is the right c-section rate is totally arguable, but what isn't arguable is that if we keep doing wrong c-section's women will be harmed if a second, third c-section is performed, the rate of uterine rupture, maternal complications etc. will be significant. The Corporate average of primary c-section rate for FY 2011 is just under 19%. Three facilities are slightly over the Corporate average rate, six facilities are slightly below the rate, and two facilities are significantly below the rate. When looking at primary c-section rates over time comparing NYC, the voluntary sector and HHC, HHC's c-section rate is lower than the voluntary sector where some facilities are over 30%. The primary c-section rate around the country is 15-18%.
- HHC's Corporate average for vaginal birth after caesarean (VBAC) is just under 20% compared to the National average of 8-10%. The VBAC graph shows significant variation amongst HHC facilities which demonstrates different practice patterns. But when we track the outcomes every facility is doing VBACs safely, we do not have evidence of either internal harm, uterine rupture etc.
- HHC Corporate average for exclusive breast feeding rate at discharge in FY 2011 was about 25%. There are four HHC facilities whose rate is greater than 30%, with Harlem Hospital in the lead. The remaining facilities range between 16% and 24%.
- HHC's Corporate average for epidural rates associated with delivery is in the low 60%.
- HHC OB summary: Out of 23,175 live infant delivery's there were seven maternal deaths in 2009, decreasing to three out of 23,024 live infant delivery's in 2010. Pregnancy complications of our patients are 8.76% with hypertension and 9.30% with diabetes. With respect to maternal complications 2.59% receive blood transfusions.
- Perinatal centers: 26% of all HHC's deliveries are admitted to the neonatal intensive care unit (NICU). 90% of the infants delivered weight greater than 2.5 kilos.
- Percentage of eligible primary care patients having cervical screening in FY 201. HHC Corporate average is 87% - target is 90%.
- The Corporation performed 100,000 mammograms in FY 2011.

2. Health Home Update

Presenting to the Committee was Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer. Dr. Wilson began the presentation by providing the background on the Federal Health Home requirements which is part of the Affordable Care Act (ACA). It establishes the authority for States to develop and receive federal reimbursement for a set of health home services for their State's Medicaid populations with chronic illness. There is a 90% Federal match for State dollars in Health Home. Health home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology and avoids unnecessary care.

The Health Home services that are specifically paid for as part of this initiative are: comprehensive care management; health promotion – transitional care including appropriate follow-up from inpatient to other settings; patient and family support; referral to community and social support services; and use of health information technology to link services.

Dr. Wilson provided the Committee with the breakdown from the NYS Medicaid perspective. There are 5.4 million NYS Medicaid recipients. Of those recipients, the NYS separated them into four categories as follows: 200,000 long term care recipients ($10.5 billion); 300,000 chronic medical recipients ($2.4 billion); 400,000 behavioral health recipients ($6.3 billion); and 50,000 intellectually, developmentally disabled recipients ($6.8 billion). NYS is focusing on the behavioral health and chronic medical recipients for health home. Of these two groups, HHC would get 128,000 recipients (Bronx – 38,000; Brooklyn – 40,000; Manhattan – 24,000; Queens – 25,000; and Staten Island – 481).

The designation process has occurred and at the end of December 2011, HHC has been certified as a Health Home in the Bronx and Brooklyn partnering with MetroPlus. The other successful certified Health Home's awardees' are: Bronx – Montefiore Medical Center, Visiting Nurse Service of New York Home Care and Bronx Lebanon Hospital Center; Brooklyn – Maimonides Medical Center, Community Health Care Network and Institute for Community Living. Applications for Manhattan and Queens close on February 1, 2012 with expected timeline of accepting patients on April 1, 2012. At the moment the time lines has slipped from the State – we were to begin seeing patients on January 1, 2012 and now scheduled for February 1, 2012 but no final word as of yet as to whether implementation will slip a little further.

Medicaid eligible individuals must have: 1) two chronic conditions 2) one chronic condition and are at risk for a second chronic condition; or 3) one serious persistent mental health condition, in order to qualify for health home services. The list of conditions include: mental health condition; substance abuse disorder; asthma; diabetes; and heart disease. Other chronic conditions covered include HIV/AIDS and hypertension. There are three tiers of complexity of the recipients that HHC will receive: 100,000 at the moderate level; 24,000 at the multiple/complex level; and 5,000 at the intense level, based on our model and 2010 data.

Projected average Health Home payments for this population varies from $39 per month to $413.00 per month based on health status and diagnoses of recipients. As the acuity goes up, based on the CIG score then the amount of money increases. The types of patients we expect to obtain are: 57.7% hypertension; 43.4% diabetes; 46% with chronic mental health of which 29% will have chronic substance abuse and 27% will have serious mental health diagnosis; and 6.6% will have HIV/AIDS.

Eligible patients are determined by the NYS Department of Health and assigned to a certified Health Homes. HHC has 90 days to locate and reach out to the patient, and if they agree to be part of the HHC Health Home, sign them up. They then need to be accessed by a primary care physician and a care manager to ensure there is a care management plan developed to meet all the patients' needs. The care management plan drives the care coordination and delivery of services. Outcomes will be measured, reported back through the plans and we will have to meet performance targets such as patient has improved health status and reduction of inpatient and emergency department use.

There being no further business the meeting adjourned at 4:03 P.M.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
February 29, 2012

Total plan enrollment as of February 1, 2012 was 425,439. Breakdown of plan enrollment by line of business is as follows:

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

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. In addition, I have attached a graph showing net transfers for the month of January 2012 for Medicaid and Family Health Plus (FHP).

MetroPlus has been ranked #1 in the City of New York for 5 out of the last 6 years based on overall quality and member satisfaction that is published in the Medicaid Consumer Guide. This year, I am pleased to announce that MetroPlus, for the first time ever, has been ranked #1 in New York State. I have attached the rankings of all 18 plans that have Medicaid patients and operate in New York State. This score is based on Quality, Consumer Satisfaction, Preventive Quality Indicators and Compliance. As you can see on the attached document MetroPlus achieved a 100% score in quality and was ranked the highest overall of all the plans in the State. These results are a testament to the excellent high quality care and service provided by all of our providers, as well as the excellent work performed by Plan staff.

Attached to my report is MetroPlus' final draft of the Strategic Plan for 2012. The plan summarizes goals and major projects for 2012. I will be submitting the plan to the MetroPlus Board of Directors for discussion and approval at the next meeting in March.

There is still much lively discussion occurring between the New York State Department of Health (SDOH) and health plans regarding the transition of the homeless population into managed care on April 1, 2012. Our Chief Medical Officer, Dr. Van Dunn is on the State's implementation workgroup. There are significant challenges to manage a population that does not have a permanent residence and might be extraordinarily difficult to contact. In addition, the State has still not finalized their expectations of how the plans will work with, and pay the homeless shelters and other homeless services.

In my report in November, I advised you of the Plan's first month experience since we took over the management of pharmacy benefits for FHP and Medicaid. As a follow up to that report, I am attaching a spreadsheet detailing the monthly pharmacy trend for October 2011 through January

2012. It shows that after four months, pharmacy costs have become more manageable, and the plan is no longer experiencing losses, after one quarter of pharmacy management.

MetroPlus is modifying some of its systems and operations to prepare for the Health Home initiative. The Plan is developing operations to assist in case finding outreach and consent to enroll individuals into the HHC/MetroPlus Health Home.

MetroPlus Medicare closed the 2011 Annual Open Enrollment Period with a total of 420 gross new members. As of February 1, 2012, we have a total of 5,694 active enrollees in all Medicare products combined. As part of our 2012 Strategic plan, we are focusing most of our Medicare sales and marketing efforts on growing the two Dual Special Needs Plans, which offer competitive health care and value added benefits for the dual eligible population. We are also in the process of reassessing our retention strategies for all Medicare lines. In general our retention rate has been maintained at over 97%.

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2012

Other Plan Name	Category	2011_02		2011_03		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		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	12	0	7	0	5	0	2	0	3	1	2	0	0	0	0	0	0	0	0	0	0	0	0	32
	VOLUNTARY	11	125	14	122	11	122	12	139	11	143	18	97	9	126	13	99	10	137	21	124	19	99	10	107	1,599
	TOTAL	11	137	14	129	11	127	12	141	11	146	19	99	9	126	13	99	10	137	21	124	19	99	10	107	1,631
CarePlus Health Plan	INVOLUNTARY	0	9	0	2	1	3	0	4	1	5	2	5	0	0	0	0	0	0	0	0	0	0	0	0	32
	VOLUNTARY	3	38	7	34	1	39	2	29	6	33	2	34	4	26	3	33	2	24	5	43	2	42	1	27	440
	TOTAL	3	47	7	36	2	42	2	33	7	38	4	39	4	26	3	33	2	24	5	43	2	42	1	27	472
Fidelis Care	INVOLUNTARY	0	7	0	19	0	7	0	8	1	3	0	3	0	0	0	0	1	1	0	0	0	0	0	0	50
	VOLUNTARY	33	246	25	237	21	227	27	196	32	280	27	211	41	252	20	176	22	201	28	257	27	237	25	223	3,071
	TOTAL	33	253	25	256	21	234	27	204	33	283	27	214	41	252	20	176	23	202	28	257	27	237	25	223	3,121
Health First	INVOLUNTARY	1	10	3	11	2	22	3	13	2	2	0	1	0	0	0	0	0	1	0	2	0	0	0	3	76
	UNKNOWN	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	54	464	39	451	42	397	29	465	45	538	35	419	45	500	35	413	38	406	42	489	39	462	27	518	5,992
	TOTAL	55	474	42	462	44	419	32	479	47	540	35	420	45	500	35	413	38	407	42	491	39	462	27	521	6,069
Health Plus	INVOLUNTARY	3	10	0	2	4	13	1	6	2	4	2	5	0	0	0	0	0	0	0	3	0	1	0	0	56
	VOLUNTARY	21	203	23	192	17	176	18	191	13	208	13	160	22	208	18	185	21	145	22	217	25	187	9	176	2,470
	TOTAL	24	213	23	194	21	189	19	197	15	212	15	165	22	208	18	185	21	145	22	220	25	188	9	176	2,526
HIP/NYC	INVOLUNTARY	0	3	1	3	1	2	1	3	0	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	18
	VOLUNTARY	12	64	14	81	13	59	9	75	3	102	10	72	8	83	6	90	11	55	12	78	12	86	11	92	1,058
	TOTAL	12	67	15	84	14	61	10	78	3	103	10	75	8	83	6	90	11	55	12	78	12	86	11	92	1,076
Neighborhood	INVOLUNTARY	0	1	1	3	0	6	1	3	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	1	20

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2012

		2011_02		2011_03		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Neighborhood Health Provider	VOLUNTARY	28	110	10	130	10	128	11	118	12	124	21	115	8	169	8	120	8	114	15	144	14	131	15	95	1,658
	TOTAL	28	111	11	133	10	134	12	121	12	124	23	117	8	169	8	120	8	114	15	144	14	131	15	96	1,678
United Healthcare of NY	INVOLUNTARY	1	2	1	3	1	4	1	3	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	18
	VOLUNTARY	12	88	15	76	14	53	5	74	11	107	11	69	14	68	10	72	7	48	18	111	16	74	14	70	1,057
	TOTAL	13	90	16	79	15	57	6	77	12	107	11	70	14	68	10	72	7	48	18	111	16	74	14	70	1,075
Wellcare of NY	INVOLUNTARY	1	2	0	4	1	5	1	2	0	3	0	5	0	0	0	0	0	0	0	0	0	0	0	0	24
	VOLUNTARY	5	16	1	14	2	15	1	29	4	26	2	33	2	27	3	22	8	18	0	10	2	29	0	20	289
	TOTAL	6	18	1	18	3	20	2	31	4	29	2	38	2	27	3	22	8	18	0	10	2	29	0	20	313
Disenrolled Plan Transfers	INVOLUNTARY	6	56	6	54	10	67	8	44	7	21	7	27	0	0	0	0	1	2	0	5	0	1	0	4	326
	UNKNOWN	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	179	1,354	148	1,337	131	1,216	114	1,316	137	1,561	139	1,210	153	1,459	116	1,210	127	1,148	163	1,473	156	1,347	112	1,328	17,634
	TOTAL	185	1,410	154	1,391	141	1,283	122	1,361	144	1,582	146	1,237	153	1,459	116	1,210	128	1,150	163	1,478	156	1,348	112	1,332	17,961
Disenrolled Unknown Plan Transfers	INVOLUNTARY	0	18	0	7	2	39	1	66	4	51	6	46	5	47	3	35	6	51	5	29	2	20	2	24	469
	UNKNOWN	0	0	0	0	0	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3
	VOLUNTARY	1	12	2	38	1	43	0	21	0	24	3	40	6	49	5	62	4	55	22	90	17	118	7	25	645
	TOTAL	1	30	2	45	3	82	2	88	4	75	9	86	11	97	8	97	10	106	27	119	19	138	9	49	1,117
Non-Transfer Disenroll Total	INVOLUNTARY	1,039	8,518	1,232	9,272	1,475	11,150	1,235	9,827	1,176	8,727	1,359	10,100	1,033	9,713	1,111	10,295	1,011	9,922	1,030	9,854	1,159	10,183	1,129	10,388	131,938
	UNKNOWN	0	0	4	1	0	2	0	7	1	1	1	0	1	2	1	3	1	3	1	4	1	2	0	0	36
	VOLUNTARY	0	64	0	81	0	83	0	67	0	61	0	42	0	52	0	50	0	54	253	386	2	59	2	49	1,305
	TOTAL	1,039	8,582	1,236	9,354	1,475	11,235	1,235	9,901	1,177	8,789	1,360	10,142	1,034	9,767	1,112	10,348	1,012	9,979	1,284	10,244	1,162	10,244	1,131	10,437	133,279

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2012

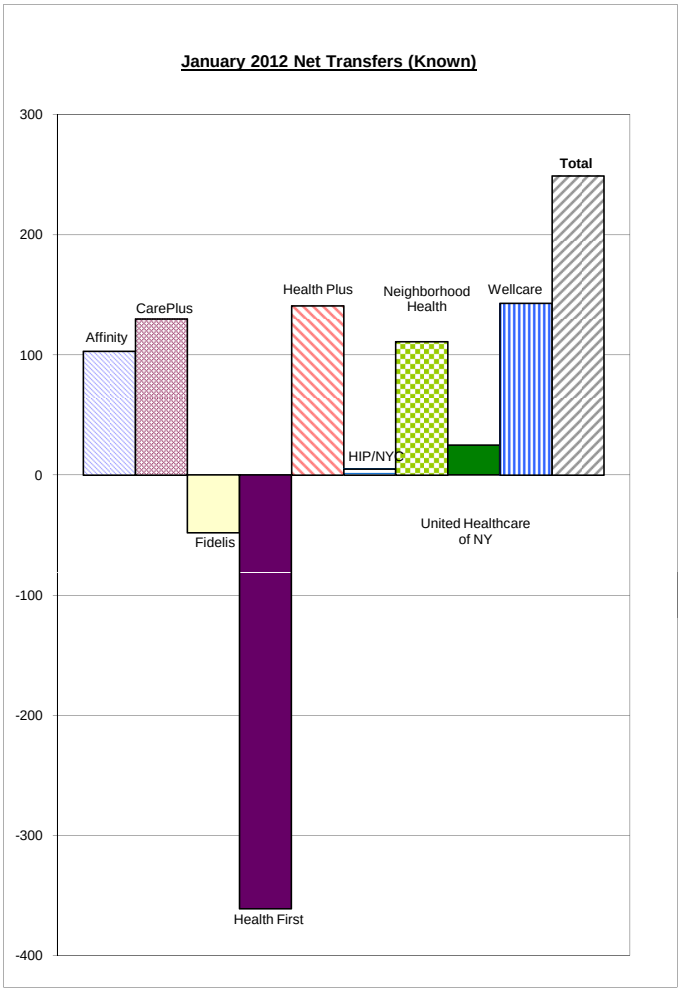
		2011_02		2011_03		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Total MetroPlus Disenrollment	**INVOLUNTARY**	1,045	8,592	1,238	9,333	1,487	11,256	1,244	9,937	1,187	8,799	1,372	10,173	1,038	9,760	1,114	10,330	1,018	9,975	1,035	9,888	1,161	10,204	1,131	10,416	132,733
	UNKNOWN	0	0	4	1	0	2	1	9	1	1	1	0	1	3	1	3	1	3	1	4	1	2	0	0	40
	VOLUNTARY	180	1,430	150	1,456	132	1,342	114	1,404	137	1,646	142	1,292	159	1,560	121	1,322	131	1,257	438	1,949	175	1,524	121	1,402	19,584
	TOTAL	1,225	10,022	1,392	10,790	1,619	12,600	1,359	11,350	1,325	10,446	1,515	11,465	1,198	11,323	1,236	11,655	1,150	11,235	1,474	11,841	1,337	11,730	1,252	11,818	152,357

Disenrollments TO Other Plans		Jan-12			Feb-11 to Jan-12		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	0	0	1	31	32
	VOL.	10	107	117	159	1,440	1,599
Affinity Health Plan	TOTAL	10	107	117	160	1,471	1,631
	INVOL.	0	0	0	4	28	32
	VOL.	1	27	28	38	402	440
CarePlus Health Plan	TOTAL	1	27	28	42	430	472
	INVOL.	0	0	0	2	48	50
	VOL.	25	223	248	328	2,743	3,071
Fidelis Care	TOTAL	25	223	248	330	2,791	3,121
	INVOL.	0	3	3	11	65	76
	VOL.	27	518	545	470	5,522	5,992
Health First	TOTAL	27	521	548	481	5,588	6,069
	INVOL.	0	0	0	12	44	56
	VOL.	9	176	185	222	2,248	2,470
Health Plus	TOTAL	9	176	185	234	2,292	2,526
	INVOL.	0	0	0	3	15	18
	VOL.	11	92	103	121	937	1,058
HIP/NYC	TOTAL	11	92	103	124	952	1,076
	INVOL.	0	1	1	4	16	20
	VOL.	15	95	110	160	1,498	1,658
Neighborhood Health	TOTAL	15	96	111	164	1,514	1,678
	INVOL.	0	0	0	5	13	18
	VOL.	14	70	84	147	910	1,057
United Healthcare of NY	TOTAL	14	70	84	152	923	1,075
	INVOL.	0	0	0	3	21	24
	VOL.	0	20	20	30	259	289
Wellcare of NY	TOTAL	0	20	20	33	280	313
	INVOL.	0	4	4	45	281	326
	VOL.	112	1,328	1,440	1,675	15,959	17,634
Disenrolled Plan Transfers:	TOTAL	112	1,332	1,444	1,720	16,241	17,961
	INVOL.	2	24	26	36	433	469
	VOL.	7	25	32	68	577	645
Disenrolled Unknown Plan Transfers:	TOTAL	9	49	58	105	1,012	1,117
	INVOL.	1,129	10,388	11,517	13,989	117,949	131,938
	UNK.	0	0	0	11	25	36
	VOL.	2	49	51	257	1,048	1,305
Non-Transfer Disenroll Total:	TOTAL	1,131	10,437	11,568	14,257	119,022	133,279
	INVOL.	1,131	10,416	11,547	14,070	118,663	132,733
	UNK.	0	0	0	12	28	40
	VOL.	121	1,402	1,523	2,000	17,584	19,584
Total MetroPlus Disenrollment:	**TOTAL**	**1,252**	**11,818**	**13,070**	**16,082**	**136,275**	**152,357**

Disenrollments FROM Other Plans	Jan-12			Feb-11 to Jan-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	13	207	220	311	2,653	2,964
CarePlus Health Plan	13	145	158	295	2,083	2,378
Fidelis Care	17	183	200	236	2,597	2,833
Health First	22	165	187	244	2,409	2,653
Health Plus	26	300	326	406	3,406	3,812
HIP/NYC	11	97	108	119	1,339	1,458
Neighborhood Health	16	206	222	251	2,068	2,319
United Healthcare of NY	8	101	109	121	959	1,080
Wellcare of NY	19	144	163	225	1,719	1,944
Total	145	1,548	1,693	2,208	19,233	21,441
Unknown (not in total)	2,162	11,740	13,902	24,763	129,946	154,709

Data Source: RDS Report 1268a&c Updated 01/23/2012

Net Difference	Jan-12			Feb-11 to Jan-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	3	100	103	151	1,182	1,333
CarePlus Health Plan	12	118	130	253	1,653	1,906
Fidelis Care	-8	-40	-48	-94	-194	-288
Health First	-5	-356	-361	-237	-3,179	-3,416
Health Plus	17	124	141	172	1,114	1,286
HIP/NYC	0	5	5	-5	387	382
Neighborhood Health	1	110	111	87	554	641
United Healthcare of NY	-6	31	25	-31	36	5
Wellcare of NY	19	124	143	192	1,439	1,631
Total	33	216	249	488	2,992	3,480



MetroPlus Health Plan

MetroPlus Health Plan
Membership Summary by LOB Last 7 Months
February-2012

		Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
Total Members	Prior Month	415.896	418.376	418.493	418.623	421.670	423.084	424.642
	New Member	17.708	15.578	15.093	19.149	16.987	17.649	17.343
	Voluntary Disenroll	1.864	1.630	1.558	2.586	1.855	2.036	1.916
	Involuntary Disenroll	13.364	13.831	13.405	13.516	13.718	14.055	14.630
	Adjusted	-29	-28	-28	-6	408	1.341	0
	Net Change	2.480	117	130	3.047	1.414	1.558	797
	Current Month	418.376	418.493	418.623	421.670	423.084	424.642	425.439
Medicaid	Prior Month	348.939	351.043	350.755	350.507	353.235	354.707	356.112
	New Member	14.371	12.294	11.913	15.552	14.058	14.075	14.317
	Voluntary Disenroll	1.561	1.323	1.257	1.949	1.521	1.459	1.569
	Involuntary Disenroll	10.706	11.259	10.904	10.875	11.065	11.211	11.937
	Adjusted	-26	-23	-21	7	409	1.429	0
	Net Change	2.104	-288	-248	2.728	1.472	1.405	811
	Current Month	351.043	350.755	350.507	353.235	354.707	356.112	356.923
Child Health Plus	Prior Month	18.927	18.784	18.856	18.899	18.878	18.712	18.216
	New Member	590	726	714	775	579	430	429
	Voluntary Disenroll	25	43	45	43	36	21	36
	Involuntary Disenroll	708	611	626	753	709	905	786
	Adjusted	1	1	1	0	7	-18	0
	Net Change	-143	72	43	-21	-166	-496	-393
	Current Month	18.784	18.856	18.899	18.878	18.712	18.216	17.823
Family Health Plus	Prior Month	34.485	34.915	35.114	35.348	35.561	35.554	35.934
	New Member	2.337	2.168	2.091	2.361	1.939	2.287	2.259
	Voluntary Disenroll	158	121	131	438	175	122	146
	Involuntary Disenroll	1.749	1.848	1.726	1.710	1.771	1.785	1.782
	Adjusted	-2	-3	-4	-7	-8	24	0
	Net Change	430	199	234	213	-7	380	331
	Current Month	34.915	35.114	35.348	35.561	35.554	35.934	36.265
HHC	Prior Month	3.037	2.980	2.986	2.976	2.998	2.989	3.082
	New Member	19	25	20	41	18	265	7
	Voluntary Disenroll	0	0	3	2	0	152	0
	Involuntary Disenroll	76	19	27	17	27	20	0
	Adjusted	0	-1	-1	3	8	-108	0
	Net Change	-57	6	-10	22	-9	93	7
	Current Month	2.980	2.986	2.976	2.998	2.989	3.082	3.089

MetroPlus Health Plan

MetroPlus Health Plan
Membership Summary by LOB Last 7 Months
February-2012

		Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
SNP	Prior Month	5.323	5.379	5.398	5.432	5.499	5.547	5.672
	New Member	178	125	142	207	165	239	148
	Voluntary Disenroll	45	47	31	39	37	36	29
	Involuntary Disenroll	77	59	77	101	80	78	98
	Adjusted	-2	-2	-3	-9	-7	24	0
	Net Change	56	19	34	67	48	125	21
	Current Month	5.379	5.398	5.432	5.499	5.547	5.672	5.693
Medicare	Prior Month	5.185	5.275	5.384	5.461	5.499	5.575	5.626
	New Member	213	240	213	213	228	353	183
	Voluntary Disenroll	75	96	91	115	86	246	136
	Involuntary Disenroll	48	35	45	60	66	56	27
	Adjusted	0	0	0	0	-1	-10	0
	Net Change	90	109	77	38	76	51	20
	Current Month	5.275	5.384	5.461	5.499	5.575	5.626	5.646

Medicare Retention Stats

Effective Month: 02/2012

	Advantage	***PIC***	***Select***	***Platinum***	***Total***
New Enrollees					
Active	130	6	3	35	174
Cancelled	23	1	1	3	28
Total New Enrollees	**153**	**7**	**4**	**38**	**202**
Disenrollments					
Rapid - Voluntary	18	0	0	4	22
Rapid - Involuntary	1	1	0	0	2
Total Rapid Disenrollments	**19**	**1**	**0**	**4**	**24**
Standard - Voluntary	25	3	4	19	51
Standard - Involuntary	4	0	0	3	7
Total Standard Disenrollments	**29**	**3**	**4**	**22**	**58**
Totals					
Subtotal Diserollments	48	4	4	26	82
Total Cancelled	**23**	**1**	**1**	**3**	**28**
Grand Total Disenrollments	**71**	**5**	**5**	**29**	**110**
Retention Status					
Expiring this Month	40	0	1	0	41
Active from Last Month	3650	394	169	1279	5492
Loss Ratio	1.10 %		0.59 %		0.75 %
Disenroll Rate	1.32 %	1.02 %	2.37 %	2.03 %	1.49 %
Member Months for Active Members	83822	11681	2284	21554	119341
Total Active Enrollees (+ Current Month Cancelled)	**3803**	**401**	**173**	**1317**	**5694**
Avg. Member Month Membership Tenture	22	29	13	16	21
General Retention Ratio	98.68 %	98.98 %	97.63 %	97.97 %	98.51 %
Total Voluntary Disenrollments	**43**	**3**	**4**	**23**	**73**
Standard Retention Ratio	98.82 %	99.24 %	97.63 %	98.20 %	98.67 %

Notes:
Data for Enrollee counts and Disenrollment counts comes from Membership. Cancelled record counts come from Market Prominence data in Data Warehouse

Loss Ratio Calculation
Expiring this Month / Active from Last Month x 100

Disenroll Rate
Subtotal Disenrollments / Active from Last Month x 100

Avg. Member Month Membership Tenure Calculation
Total # Months each Active Member is Enrolled / Total Active Enrollees including Current Month Cancelled Members (Rounded)

General Retention Ratio Calculation
Active From Last Month + Total Cancelled - Grand Total Disenrollments /Active from Last Month x 100

Standard Retention Ratio Calculation
Active From Last Month - Total Voluntary Disenrollments /Active from Last Month x 100

New Member Transfer From Other Plans

	2011_02		2011_03		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		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	18	241	19	224	19	209	35	241	42	273	37	231	51	264	16	194	21	175	23	203	17	191	13	207	2,964
CarePlus Health Plan	30	181	22	163	33	202	20	172	23	203	35	137	29	223	25	198	25	135	28	177	12	147	13	145	2,378
Fidelis Care	17	203	11	194	14	207	25	201	29	260	17	200	26	293	19	234	24	173	19	232	18	217	17	183	2,833
Health First	26	201	14	176	14	185	18	225	25	248	22	219	26	242	25	148	14	186	25	216	13	198	22	165	2,653
Health Plus	29	278	33	284	42	299	33	238	51	349	29	273	30	343	34	258	38	255	32	254	29	275	26	300	3,812
HIP/NYC	15	90	6	116	12	125	12	133	10	126	10	122	15	113	10	117	6	94	7	102	5	104	11	97	1,458
Neighborhood Health Pr	15	163	12	187	25	196	14	181	32	213	16	162	15	175	25	139	26	149	24	171	31	126	16	206	2,319
United Healthcare of NY	5	57	9	60	12	75	17	59	13	72	12	76	11	77	10	83	6	72	8	102	10	125	8	101	1,080
Unknown PLan	1,633	9,924	1,991	10,421	2,014	9,445	2,171	9,838	2,527	13,610	2,160	10,215	2,145	11,424	2,022	9,708	1,927	9,392	2,191	12,783	1,820	11,446	2,162	11,740	154,709
Wellcare of NY	16	174	21	131	16	157	19	132	24	157	15	123	21	157	11	127	20	146	28	145	15	126	19	144	1,944
TOTAL	1,804	11,512	2,138	11,956	2,201	11,100	2,364	11,420	2,776	15,511	2,353	11,758	2,369	13,311	2,197	11,206	2,107	10,777	2,385	14,385	1,970	12,955	2,307	13,288	176,150

Monthly Pharmacy Trended Expenses

All Lines of Business

	Months	Cost	pmpm	DOH Rate*	Var., PMPM	*CVS Est.*
October	391,284	$ 40,174,004	$ 102.67	$ 98.41	$ (4.26)	
November	394,279	36,944,507	93.70	98.90	5.20	
December	395,754	36,564,197	92.39	99.11	6.72	
January	397,733	34,981,368	87.95	99.92	11.97	
To-Date	**1,579,050**	**$ 148,664,076**	**$ 94.15**	**$ 98.41**	**$ 4.27**	
Exc. HIVSNP	***1,556,901***	***$ 108,194,432***	***$ 69.49***	***$ 72.31***	***$ 2.81***	

Medicaid

	Months	Cost	pmpm	DOH Rate	Variance	
October	350,504	$ 27,377,032	$ 78.11	$ 71.85	$ (6.26)	
November	353,219	24,698,933	69.93	72.21	2.29	
December	354,653	24,269,992	68.43	72.25	3.81	
January	355,612	22,237,152	62.53	72.54	10.01	
To-Date	**1,413,988**	**$ 98,583,109**	**$ 69.72**	**$ 71.85**	**$ 2.13**	***$ 67.77***

FHP

	Months	Cost	pmpm	DOH Rate	Variance	
October	35,348	$ 2,877,875	$ 81.42	$ 76.85	$ (4.57)	
November	35,561	2,461,961	69.23	76.85	7.62	
December	35,554	2,225,582	62.60	76.85	14.25	
January	36,450	2,045,904	56.13	76.85	20.72	
To-Date	**142,913**	**$ 9,611,322**	**$ 67.25**	**$ 76.85**	**$ 9.60**	***$ 86.45***

HIVSNP

	Months	Cost	pmpm	DOH Rate	Variance	
October	5,432	$ 9,919,097	$ 1,826.05	$ 1,952.91	$ 126.87	
November	5,499	9,783,612	1,779.16	1,955.97	176.81	
December	5,547	10,068,623	1,815.15	1,959.09	143.94	
January	5,671	10,698,312	1,886.49	1,965.21	78.71	
To-Date	**22,149**	**$ 40,469,644**	**$ 1,827.15**	**$ 1,952.91**	**$ 125.76**	***$ 1,675.40***

*Member mix adjusted

Attachment A

2011 Quality Incentive Awards

Incentive Premium Award (%)	Plan Name	Quality Points (100 points possible)	Satisfaction Points (30 points possible)	PQI Points (20 points possible)	Compliance Points (20 points possibly subtracted)	Total Points (150 points possible)	Percent (up to 100%)
2.5	MetroPlus Health Plan	100.0	20	8.5	-2	126.5	84
1.5	Neighborhood Health Providers	85.4	5	10	0	100.4	67
1.5	Fidelis Care New York	73.4	15	11.5	0	99.9	67
1.5	HIP (EmblemHealth)	97.4	10	0	-8	99.4	66
1.5	Hudson Health Plan	56.9	30	14	-2	98.9	66
1.5	Health Plus	79.4	10	12.5	-6	95.9	64
0.5	UnitedHealthcare Community	58.4	15	12.5	-6	79.9	53
0.5	Affinity Health Plan	65.9	15	6	-10	76.9	51
0.5	HealthNow New York Inc.	50.8	20	6.5	-6	71.3	48
0.5	Healthfirst PHSP, Inc.	43.4	15	13.5	0	71.9	48
0.5	CDPHP	35.4	25	10	-2	68.4	46
0.5	Univera Community Health	38.5	25	10	-6	67.5	45
0.0	Independent Health's MediSource	30.8	30	10	-6	64.8	43
0.0	Amerigroup New York	43.4	10	13.5	-6	60.9	41
0.0	MVP	36.0	20	10	-6	60	40
0.0	Excellus BlueCross BlueShield	33.8	20	8	-6	55.8	37
0.0	WellCare of New York	50.8	0	10	-6	54.8	37
0.0	Total Care	24.6	5	11.5	0	41.1	27

MetroPlus Health Plan

Strategic Plan – 2012

February 1, 2012

Strategic Plan – 2012

Our Strategic Plan has been designed to ensure that MetroPlus is a fiscally sound plan that is viewed as the Number #1 Health Plan by our customers, our staff, HHC, providers, members, government and other outside entities.

Strategic Plan – 2012

- ***The foundation of our Strategic Plan will be built in six (6) major areas:***
  - Growth & Development
  - Maintain Financial Stability
  - Improving Medical Outcomes
  - Continued Focus on Compliance
  - Improving Organizational Effectiveness - Technological Excellence
  - Improving Organizational Effectiveness - People and Processes

Strategic Plan – 2012

- ***Continue to consistently increase the total Growth and Development of the Plan by:***
  - Adding new mandated products (MLTC).
  - Expanding existing products where appropriate (Dental, Medicare).
  - Expanding into new product lines (Behavioral Health SNP).
  - Building on existing successes in enrollment & developing new approaches to marketing of existing products, (Medicaid, CHP, FHP).
  - Continually striving to improve member satisfaction.
  - Increasing and enhancing electronic media sources.

Strategic Plan – 2012

- Focus on the Medicare lines of business with a target growth of 26% for 2012 to reach 7,200 members
  - Enhance relationships with Providers and Community Based Organizations to generate potential Dual Eligible Referrals
- Refining processes & services that enhance retention of existing members.
- Developing programs that can be delivered through the Exchanges planned as part of Health Care Reform.
- The 2012 year end membership target number is 440,000.

Strategic Plan – 2012

- ***Maintain Financial Stability to provide care of our members by doing the following:***
  - Monitor proposed & final budget and rate setting approaches; provide feedback to all appropriate stakeholders.
  - Maximize revenue with CRG's via MEDS and HCC's via RAPS submissions.
  - Achieve 2012 revenue & expense budget targets.
  - Continue to work with HHC to reinforce the need for complete coding for accuracy in CRG's RAPS and QARR data collections.

Strategic Plan – 2012

- Ensure that medical dollars are used effectively:
  - Successful implementation of the CVS Caremark Pharmaceutical Benefit Management services for all lines of business.
  - Continued refinement of the management of personal care services.
  - Set up all processes and systems for a successful implementation of the MLTC business line.
  - Develop effective processes to manage the homeless population that will become effective as of April 1, 2012.
  - Continued development of an internal process for DRG reviews.
  - Continue to use NY County Health Services Review Organization (NYCHSRO) for analyzing DRG's on high cost claims.
  - Successfully implement ICD-10 changes.

Strategic Plan – 2012

- Develop options for a data repository that would facilitate review and coordination of financial and QM data.
- Monitor other administrative costs that could be reduced; develop plans to address same.
- Enhance the use of Business Intelligence Software to improve the plan's ability to make sound business decisions.

Strategic Plan – 2012

- ***Improving Medical Outcomes for Members:***
  - Actively participate in the development and implementation of the HHC-MetroPlus Health Home:
    - Actively participate in all of the planning workgroups.
    - Implement systems for outreach , consent & engagement of potential Health Home members
    - Actively involve the HHC Health & Home Care Provider in appropriate points of care.
  - Align case management with QARR goals & outcomes; determine how to increase member engagement.
    - Focus on engaging more members on the Impact Pro List to provide problem focused interventions.

Strategic Plan – 2012

- Make sure that primary care and appropriate specialty care visits are occurring.
- Work closely with HHC to increase case management (CM) referrals (including high risk OB members), member focused education and improve QARR scores.
- Behavioral Health CM will work with HHC Home Care to improve linkage to timely outpatient mental health care after an inpatient behavioral health admission.
- Identify appropriate CM indicators to track.

- Achieve a #1 ranking as a Medicaid Managed Care Health Plan in NYC, based on indicators chosen by the NYSDOH including QARR.
- Improve Medicare Star Ratings to at least a level 4 for the coming year.

Strategic Plan – 2012

- Re-evaluate the existing Pay for Performance Program (P4P) & develop a new cohesive dashboard report that incorporates key elements of MetroPlus' initiatives and priorities.
- Enhance effectiveness of utilization management strategy, including focused reviews, member outreach for frequent ER utilization and discharges from OON facilities, reducing unnecessary hospitalizations and readmissions, and improved tracking in DCMS.
- Continuously work with our providers to improve provider satisfaction based on survey results.

Strategic Plan – 2012

- ***Continued Focus on Compliance:***
  - Comply with all regulatory and HHC requirements.
  - Successfully complete New York State Department of Health and CMS audits.
  - Focus on compliance with all NYS & CMS changes including new populations, benefits and requirements.
  - Continued enhancement of the Special Investigation Unit (SIU) to review potential fraud & abuse; and improve the level of financial recovery in identified cases.
  - Ensure that MetroPlus is compliant with all regulatory requirements.

Strategic Plan – 2012

- Review contracts & RFP's to make sure we comply with all regulatory and HHC requirements.
- Conduct internal audits; share findings and implement recommended changes.
- Update "MetroPlus Compliance Program Guidelines" as needed, consistent with HHS-OIG and NYS-OMIG standards.

Strategic Plan – 2012

- ***Improving Organizational Effectiveness – Technological Excellence:***
  - Apply technological solutions to improve the operational effectiveness of the health plan wherever possible.
  - Develop technology strategy to meet MetroPlus' long term needs.
  - Complete organizational needs assessment & begin development to allow for a potential core system replacement.
  - Continue to refine & update our business resumption plan to keep up with company growth and the ever changing business requirements to minimize the effects of any interruption.

Strategic Plan – 2012

- ***Improving Organizational Effectiveness – People and Processes:***
  - Develop & enhance training programs, including online learning.
  - Implement a Project Management approach for major projects.
  - Develop and implement a Succession Plan.
  - Identify career development opportunities.
  - Continue to recruit qualified candidates.
  - Improve employee satisfaction based on input from Employee Surveys.

A Roadmap for Business Intelligence

Paul Contino

Chief Technology Officer

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

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POPULAR SCIENCE
THE FUTURE NOW
THE CONTROL CENTERS
OFFICER ALGORITHM
NEW WAYS OF SEEING
PLUS
SPECIAL ISSUE
DATA IS POWER
HOW INFORMATION IS DRIVING THE FUTURE
The Economist
FEBRUARY 27TH–MARCH 5TH 2010
Economist.com
Obama the warrior
Misgoverning Argentina
The economic shift from West to East
Genetically modified crops blossom
The right to eat cats and dogs
The data deluge
AND HOW TO HANDLE IT: A 14-PAGE SPECIAL REPORT
MIT Sloan Management Review
RESEARCH REPORT
FALL 2010
In collaboration with IBM Institute for Business Value
IBM
Analytics: The New Path to Value
How the Smartest Organizations Are Embedding Analytics to Transform Insights Into Action
nature
THE BITER BIT
Viral infections for viruses
TROPICAL CYCLONES
The strange get stronger
BLACK HOLE PHYSICS
A new window on the Galactic Centre
BIG DATA
SCIENCE IN THE PETABYTE ERA

1.8 zettabytes**

The amount of information created in 2011

1 zettabytes = 1 billion terabytes = 1 x 10^{21}

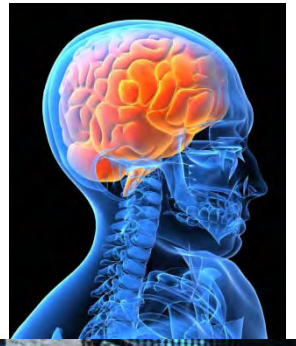
Prediction :

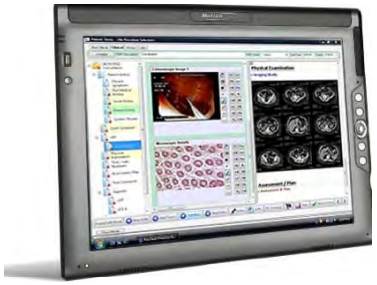
Between 2009 and 2020, digital data will grow 44 fold to 35 zettabytes per year

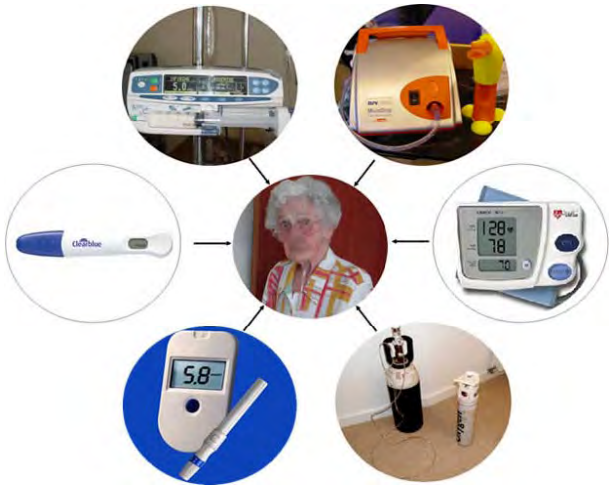
Source: IDC Digital Universe Study, May 2010

1-3 Terabytes per Patient

- ✓Electronic Medical Records
- ✓Medical Imaging (CT/PET/MRI)
- ✓Personal Health Records
- ✓Home Medical Devices
- ✓Omics Data (Proteomics / Genomics)







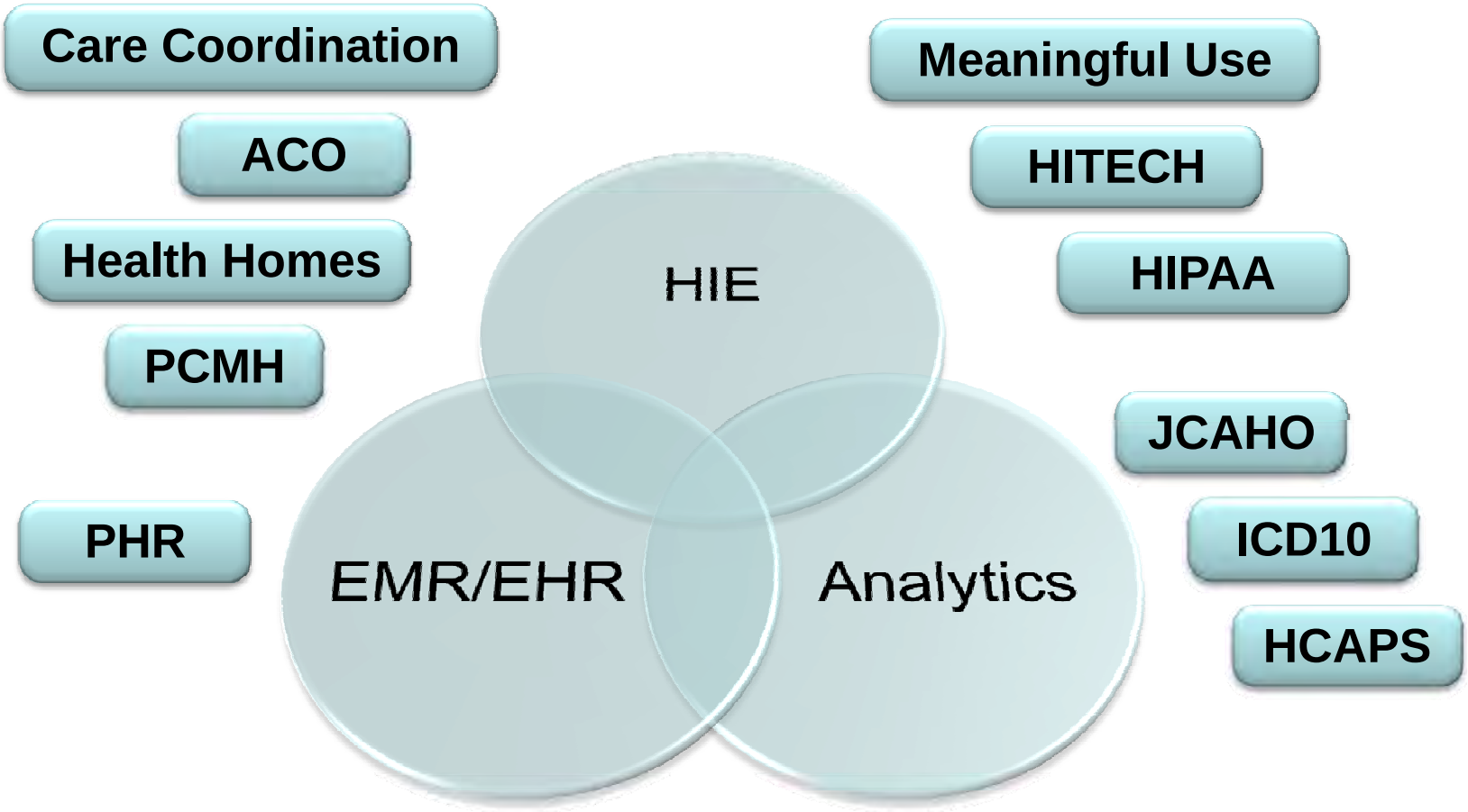
Gartner CIO Technology Priorities for 2012

✓Analytics and Business Intelligence – Top Priority

CIO technologies	Ranking of technologies CIOs selected as one of their top 3 priorities in 2012				
Ranking	***2012***	**2011**	**2010**	**2009**	**2008**
Analytics and business intelligence	1	5	5	1	1
Mobile technologies	2	3	6	12	12
Cloud computing (SaaS, IaaS, PaaS)	3	1	2	16	*
Collaboration technologies (workflow)	4	8	11	5	8
Virtualization	5	2	1	3	3
Legacy modernization	6	7	15	4	4
IT management	7	4	10	*	*
Customer relationship management	8	18	*	*	*
ERP applications	9	13	14	2	2
Security	10	12	9	8	5
Social media/Web 2.0	11	10	3	15	15

The study, conducted in the fourth quarter of 2011 and entitled "Amplifying the Enterprise: The 2012 CIO Agenda," polled 2,335 CIOs covering 37 industries in 45 countries and representing some $321 billion in IT budgets.

Business Intelligence & Health Analytics



What is Business Intelligence?

- Business Intelligence is the processes, technologies, and tools that help us change data into information, information into knowledge and knowledge into decisions and action

- Technologies for gathering, storing, analyzing and providing access to data to help enterprise users make better business decisions

What is Business Intelligence?

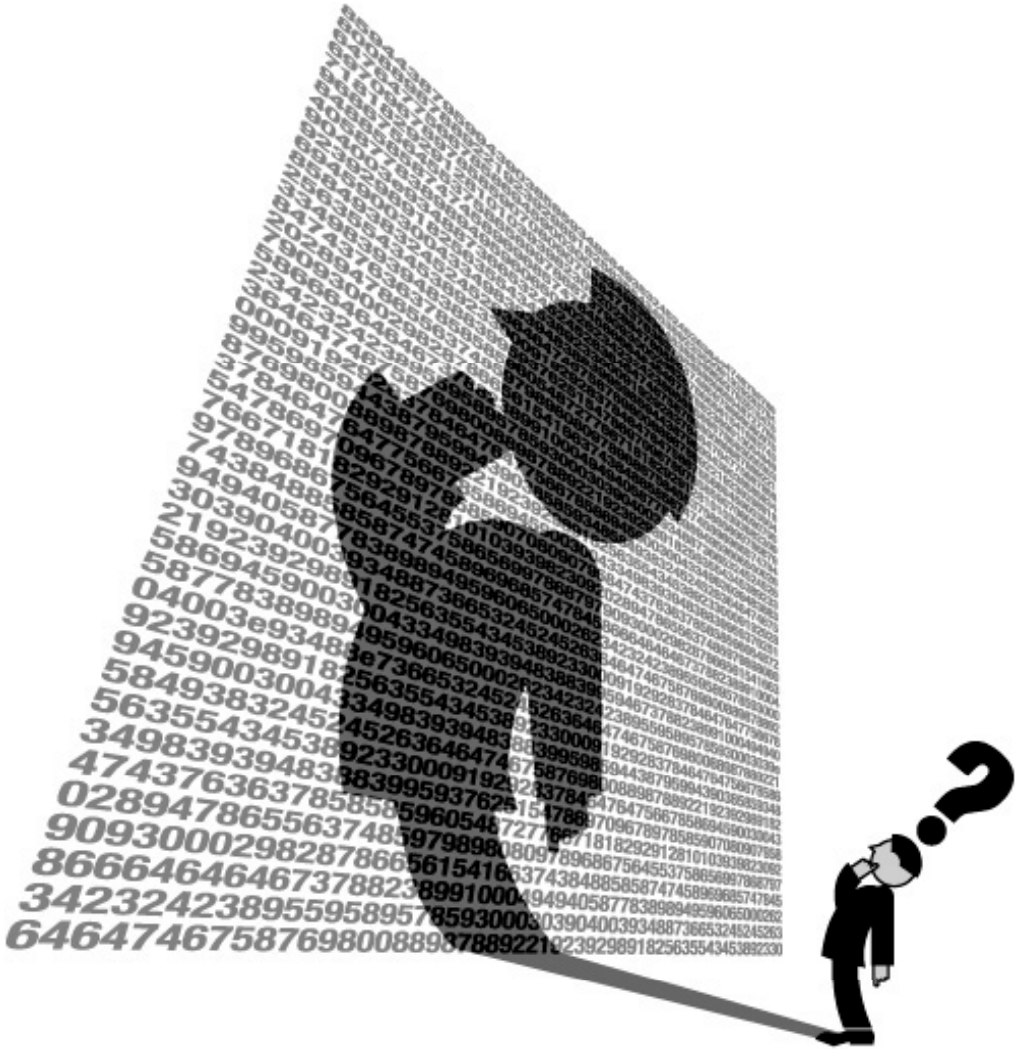
- **Business Intelligence (BI) is about getting the right information, to the right decision makers, at the right time.**
- **BI is an enterprise-wide platform that supports reporting, analysis and decision making.**

•BI leads to:

"Single Source of the Truth"

Fact-Based Decision Making

Drowning in Data… but Starving for Information



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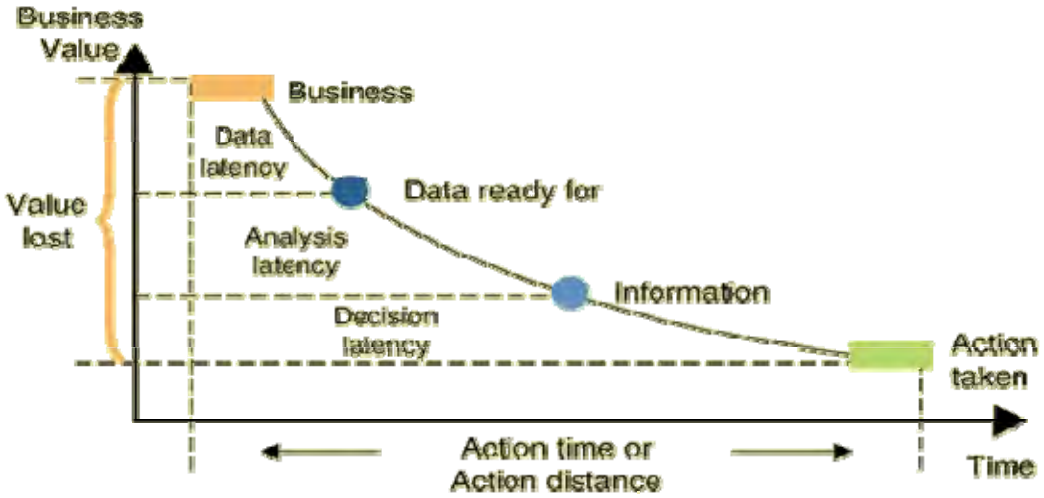
The Pain Points - Data Everywhere, Information No Where

- Need to cross-reference data from multiple systems
- Various offices, departments produce similar data displays utilizing a variety of methods, calculations, methodologies
- Data not always extracted with same methodology
- Manual effort repeated monthly, weekly, daily across multiple departments
- Inability to reconcile

Business Intelligence

	Operational BI	Tactical BI	Strategic BI
Business focus	Manage daily operations, integrate BI with operational systems	Conduct short-term analysis to achieve strategic goals	Achieve long-term organizational goals
Primary users	Managers, analysts, operational users	Executives, managers	Executives, managers
Time frame	Intraday	Day(s) to weeks to months	Months to years
Data	Real-time metrics	Historical metrics	Historical metrics



Benefits –

- Improve efficiency of legacy financial and clinical systems and processes
- Monitor and analyze key metrics and objectives, including quality, safety, risk, and compliance
- Provide insight and analytics around clinical performance and patient care
- Expand access to and availability of information to support decision-making
- Identify areas of competitive strength and weakness

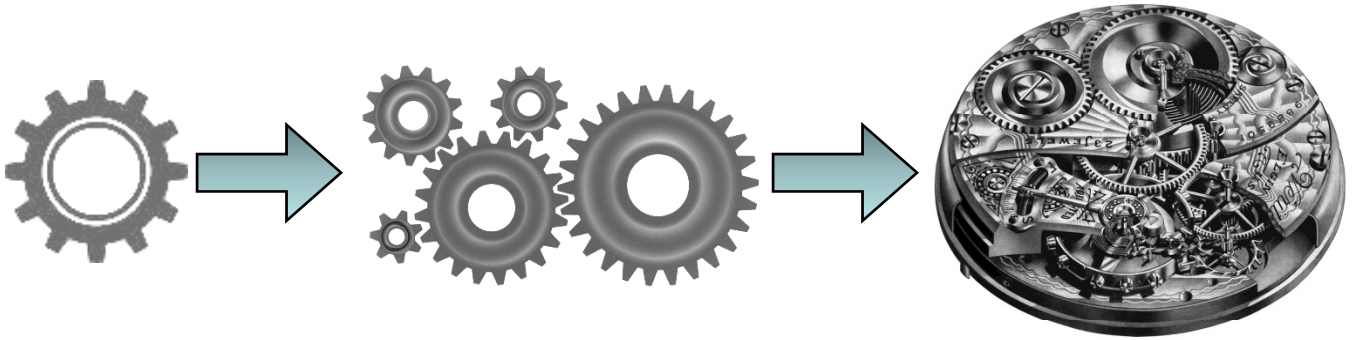
Maturity Model for Business Intelligence

BI and the Road Ahead

- Enterprise Business Intelligence initiative
- BI Executive Steering Committee – to ensures that BI meets our strategic needs and supports HHC's goals and mission
- Governance –
  - create a Business Intelligence Competency Center (BICC) that represents all lines of business
  - create processes that enforce data integrity principles & support data quality initiatives
  - Data / metric definitions & standardization, change control
- Enterprise Data Warehouse - integrated view of our data assets from across corporation
- Clinical, Financial, Supply Chain, Human Resource
- **Data = Corporate Asset**

Becoming A Data-Driven Organization

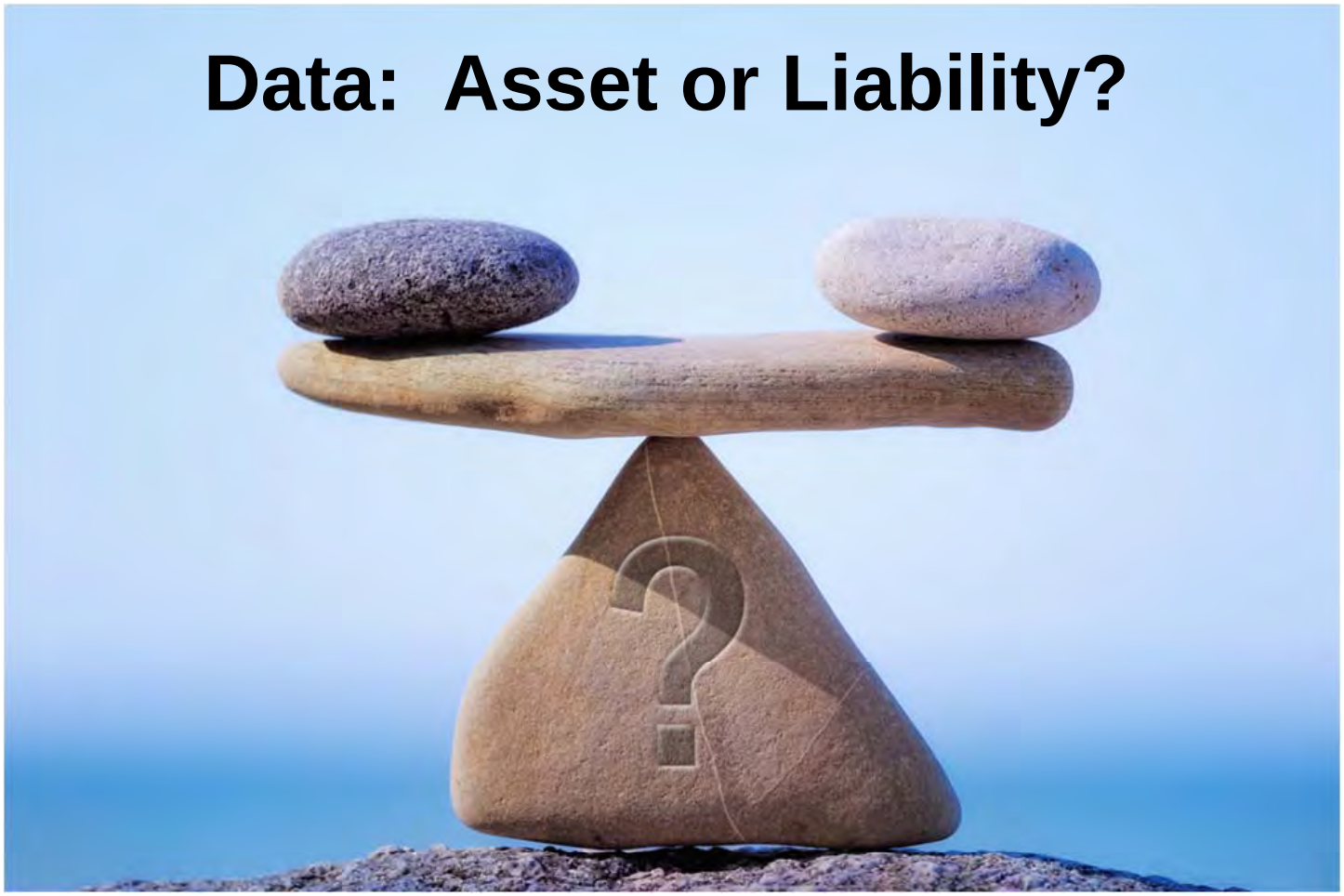
“A good decision, made in the absence of knowledge, is merely a lucky one.”



Data – Intelligence – Insights – Decisions

“Without data that is **consistent, accurate and reliable** across the enterprise, an organization can easily reach misleading, faulty and potentially harmful conclusions“

Data: Asset or Liability?



Data: Asset with BI

Data Governance Framework

Data Accessibility | Data Availability | Data Quality | Data Consistency | Data Security | Data Auditability

Standards

- Data Definitions & Taxonomies
- Master Data & Reference Data
- Enterprise Data Model
- Technology & Tools

Policies & Processes

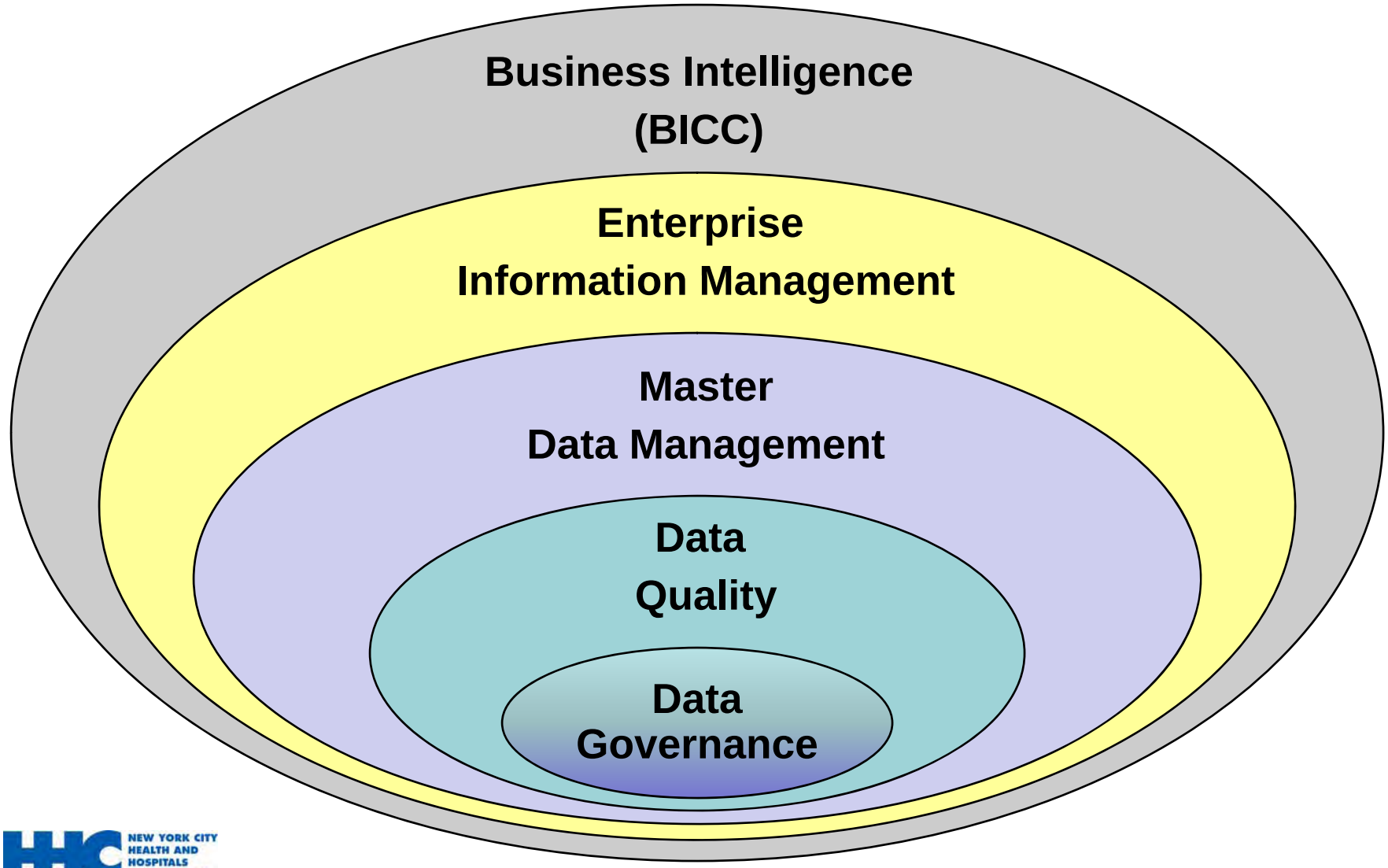
- Data Definition
- Change Management
- Access & Delivery
- Monitoring & Measurement

Organization

- Roles & Responsibilities
- Training & Education
- Planning & Prioritization
- Organization Change Management

Data Integration Infrastructure

Data Governance is a Foundation for BI



Conceptual BI Architecture

End Users

- Executive Team Information
- Quality Management Information
- Physician/Clinical Management Information
- Financial Information
- Facility Operations Information

Value Delivered

Integrated Data View (Best Source of Truth)

- ✓ Presentation, Personalization
- ✓ Access (Report / Data) / Authorization

Enterprise Portal
(Provides a single, secure and integrated point of access to reports, content, and applications)

- Dashboard / Scorecard
- Graphs / Charts
- Ad-hoc Reporting
- Drill Down
- Role based Security

- ✓Online Analytical Processing
- ✓ Pre-Defined Data Cubes
- ✓ Pre-Defined Reporting

Business Intelligence
(Provides reporting and analytic capabilities across varying levels of granularity and timeliness (e.g., historical, operational, Predictive and what-if analysis)

- Operations
- Finance
- Revenue Cycle
- Clinical
- Quality
- Supply Chain

- ✓ Enterprise Data Warehouse
- ✓ Historical data
- ✓Data Security

Data Aggregation and Storage
(Comprises the data repository of historical details and summary transaction data)

- Fact Tables
- Conformed Dimensions
- Subject Mater Data Marts
- Master Data (e.g. EMPI)
- Metadata
- Data Security

- ✓ Data Extraction
- ✓ Data Cleansing
- ✓ Data Loading

Data Integration
(Comprises the processing engine to collect, cleanse, transform, and aggregate data from different sources)

- Data Mapping
- Data Extract, Transform, Load
- Data Merge / De-duplication
- Data Cleansing
- Data Enrichment

- ✓ Data Sources, Real time data
- ✓ Certain operational reports

Data Acquisition
(Comprises internal, external, reference, and shared sources of data)

Revenue Mgmt	Quality	Clinical	Finance	Supply Chain	HR
Billing, CDM, MRN, Patient ID	Patient Satisfaction, Core Measures, External Data , Chart Audits	EHR, Dept Systems (OR, Radiology, Cardiology)	AP, GL, RVU Cost, Budget, Fixed Assets	Acquisition cost, Supplies, Item master, Contracts	HR, Benefits, Payroll, T&A

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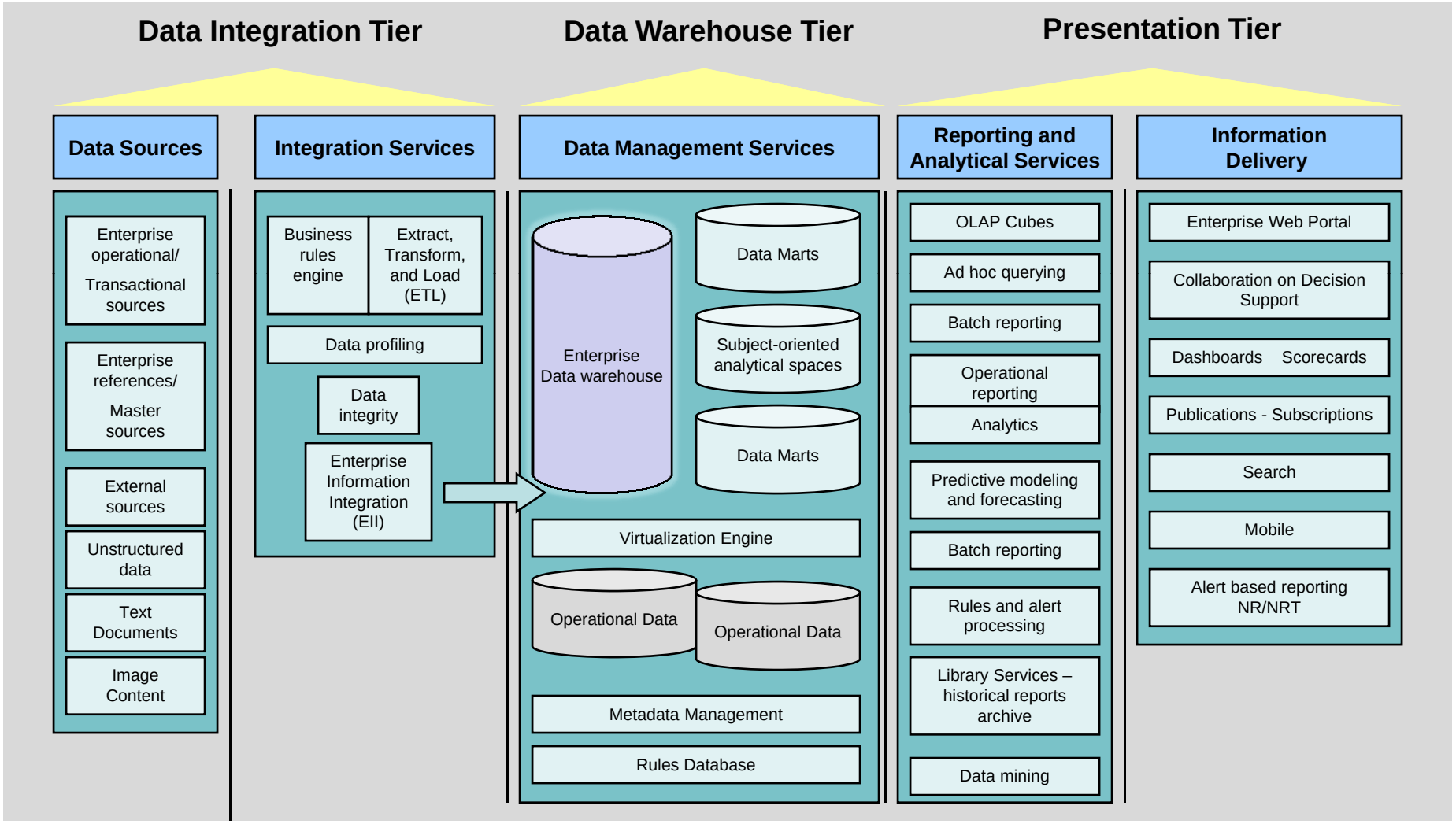
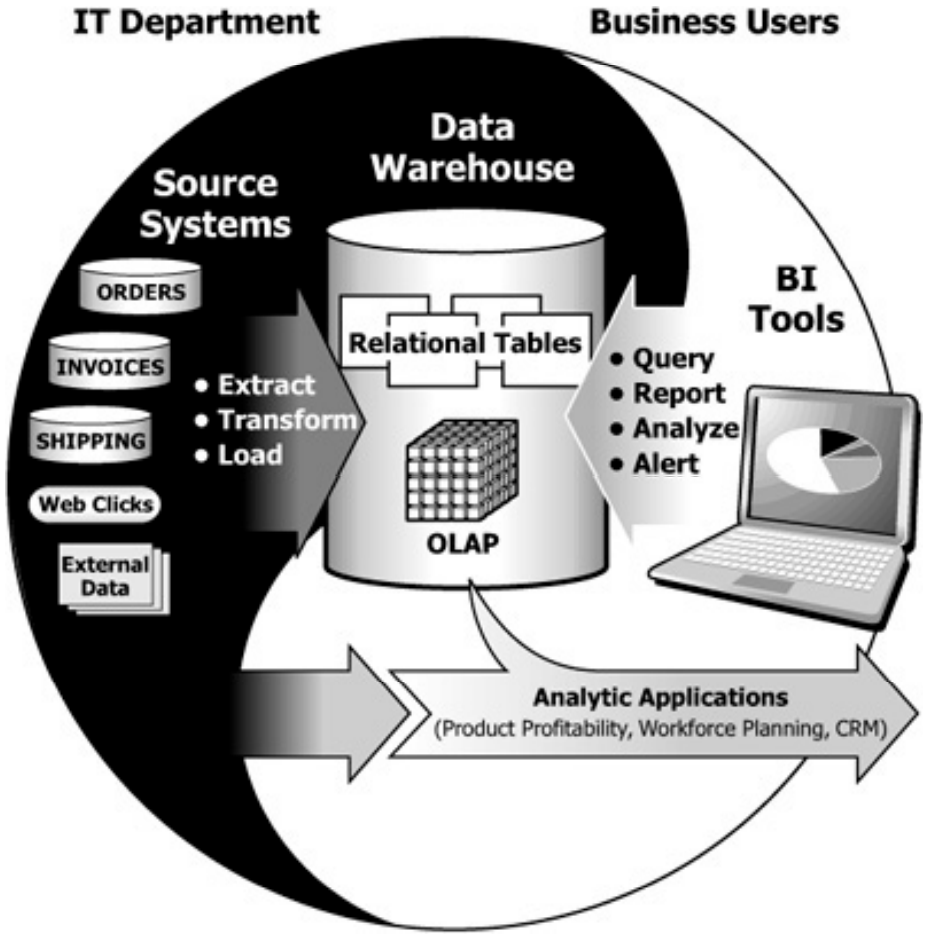
The Technical Framework For BI



Business Intelligence

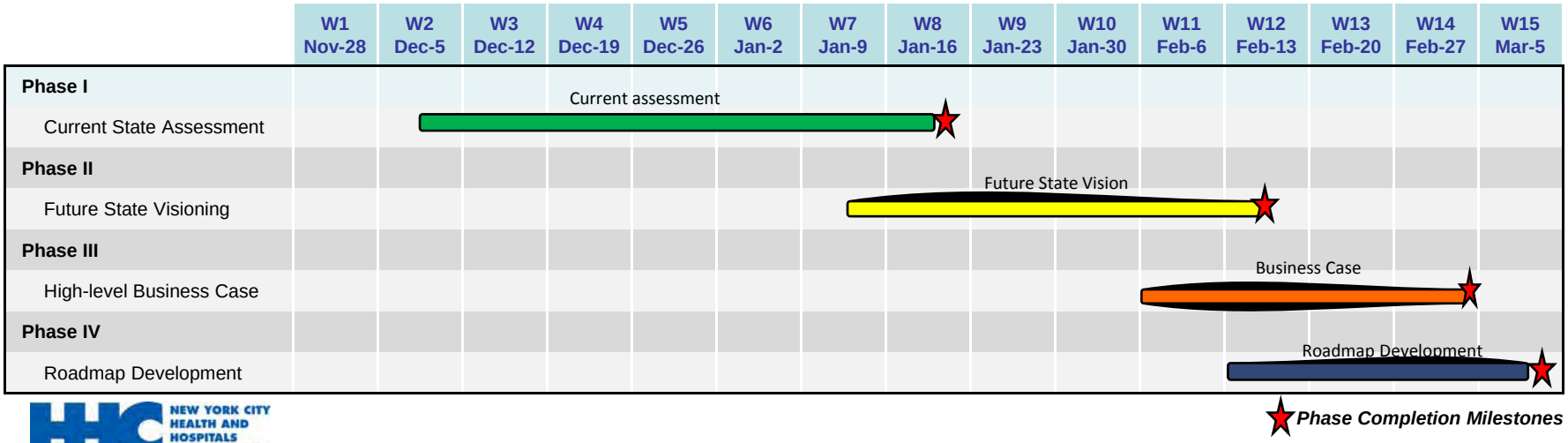
Major Components -

- Data Integration / Migration
- Data Governance
- Data Quality
- Data Modeling
- Data Profiling
- Data Synchronization
- Master Data Management (MDM)
- Metadata Management
- Data Federation
- ETL (extraction/transformation/load)
- Reporting & Analytics
- Key Performance Indicators (KPI)
- Metrics / Dashboards
- Information Portals



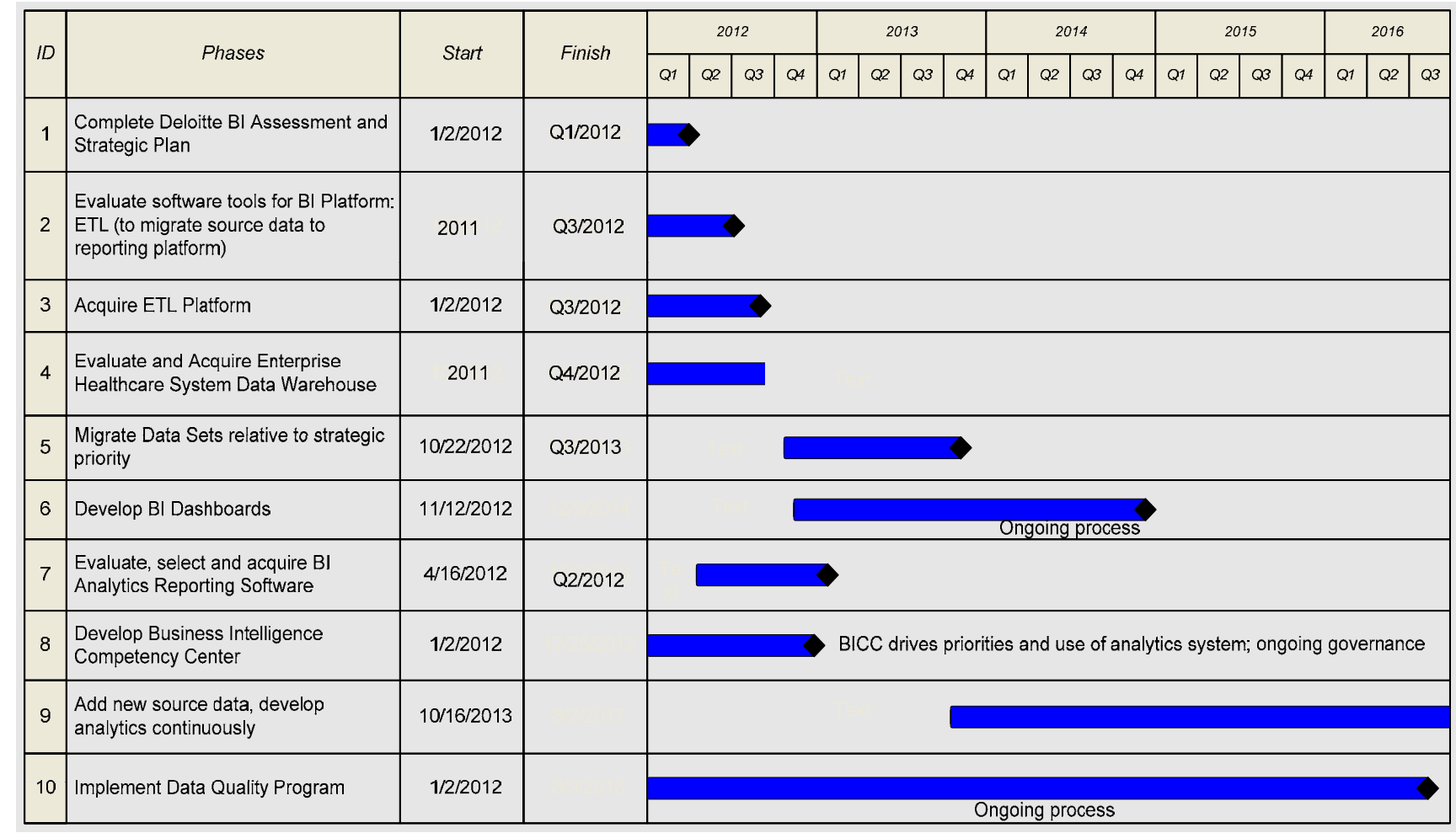
Business Intelligence Strategic Assessment

Current State Assessment	• **Conduct a current state assessment of HHC's enterprise BI environment including needs, support processes, data governance, data warehouses, information quality, and support services.** ➢ **HHC BI team has conducted a preliminary assessment on the current state, which was used as part of the BI Strategy definition.**
Future State Visioning	• **Develop future state recommendations required to support enterprise wide information and analytics needs, and initiatives through implementation of Enterprise Data Warehouse.** • **Outline a framework to develop data standards, link disparate data assets, consolidate discrete data silos (internal and third party) and further develop analytical capabilities.** • **Recommendations to develop a service oriented support model for data governance and data analytics.**
High-Level Business Case	• **Define project investment, timing and resource requirements.** • **Assess the associated tangible and intangible benefits.**
Roadmap Development	• **Develop a roadmap with current to future state transition plan that aligns Information Technology & business initiatives.** • **Recommend data quality & integration techniques along with technologies that support a services oriented platform.**



BI Planning and Implementation Timeline

ID	Phases	Start	Finish
1	Complete Deloitte BI Assessment and Strategic Plan	1/2/2012	Q1/2012
2	Evaluate software tools for BI Platform: ETL (to migrate source data to reporting platform)	2011	Q3/2012
3	Acquire ETL Platform	1/2/2012	Q3/2012
4	Evaluate and Acquire Enterprise Healthcare System Data Warehouse	2011	Q4/2012
5	Migrate Data Sets relative to strategic priority	10/22/2012	Q3/2013
6	Develop BI Dashboards	11/12/2012	Ongoing process
7	Evaluate, select and acquire BI Analytics Reporting Software	4/16/2012	Q2/2012
8	Develop Business Intelligence Competency Center	1/2/2012	BICC drives priorities and use of analytics system; ongoing governance
9	Add new source data, develop analytics continuously	10/16/2013	
10	Implement Data Quality Program	1/2/2012	Ongoing process



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Questions & Answers

Appendix Slides

Technical Architecture

Integration Services:

- Metadata dictionary: a platform that acts as a dictionary to our data
- ETL process closely entwined with dictionary, so ETL rules are maintained in same system
- Allows end-users to interrogate and view data lineage
- Dictionary maintains both business definition as well as technical information required to deliver end result

Data Quality

- Profiling, modeling, quality measures applied via business rules engine
- Allows for data migration planning, and ongoing data quality monitoring

ETL (Extraction, Transform, Load):

- Tool tied to metadata platform
- Wide db adapter support allows access to any system
- Scheduling, monitoring, alerting of ongoing processes

Data Management Services

Enterprise Data Warehouse:

- Combining data from across many functional areas
- Technology platform capable of supporting "Big Data" such as Terradata, Exadata
- Virtualization of certain data sources for real-time and near real time use

Data Marts:

- Supported directly by key platform, data marts are constructed to address health questions, populations or specific Lines of Business.
- Built into data model at outset
- Designed to provide efficient data viewing at dashboard level with minimum effort

Reporting and Analytics

Deploy a variety of data delivery solutions as different audiences require different modes

- Fixed dashboards with ability to drill into details, change certain pre-set parameters
- Ad-hoc analysis over developed data sets, containing the metadata the user needs to understand the origin and lineage
- Batch delivery where indicated
- Predictive modeling and forecasting
  - Applied by developing data sets, functions, displays to assist management on an ongoing basis.
- Alert based: deliver reports when outliers occur
- Data mining: with specialized tools, exploration of large data sets to seek out relationships

Enterprise Web Portal

- Single portal to access data from multiple systems.
- As EDW and enterprise solutions are built, portal becomes sole option for all reports, dashboards
- Collaboration tools:
  - Utilize socially aware tools to allow users to interact on data; rather than cut & paste and email stale data across the wire.
  - Used to highlight when an intervention took place; document accountability; note responses on results for perpetuity
- Customizable dashboards
- Subscriptions: allow users to auto-generate reports on schedule
- Mobile delivery
- Alerts built into all delivery options so only data that needs to be seen is highlighted – the outliers

Business Intelligence Competency Center (BICC)

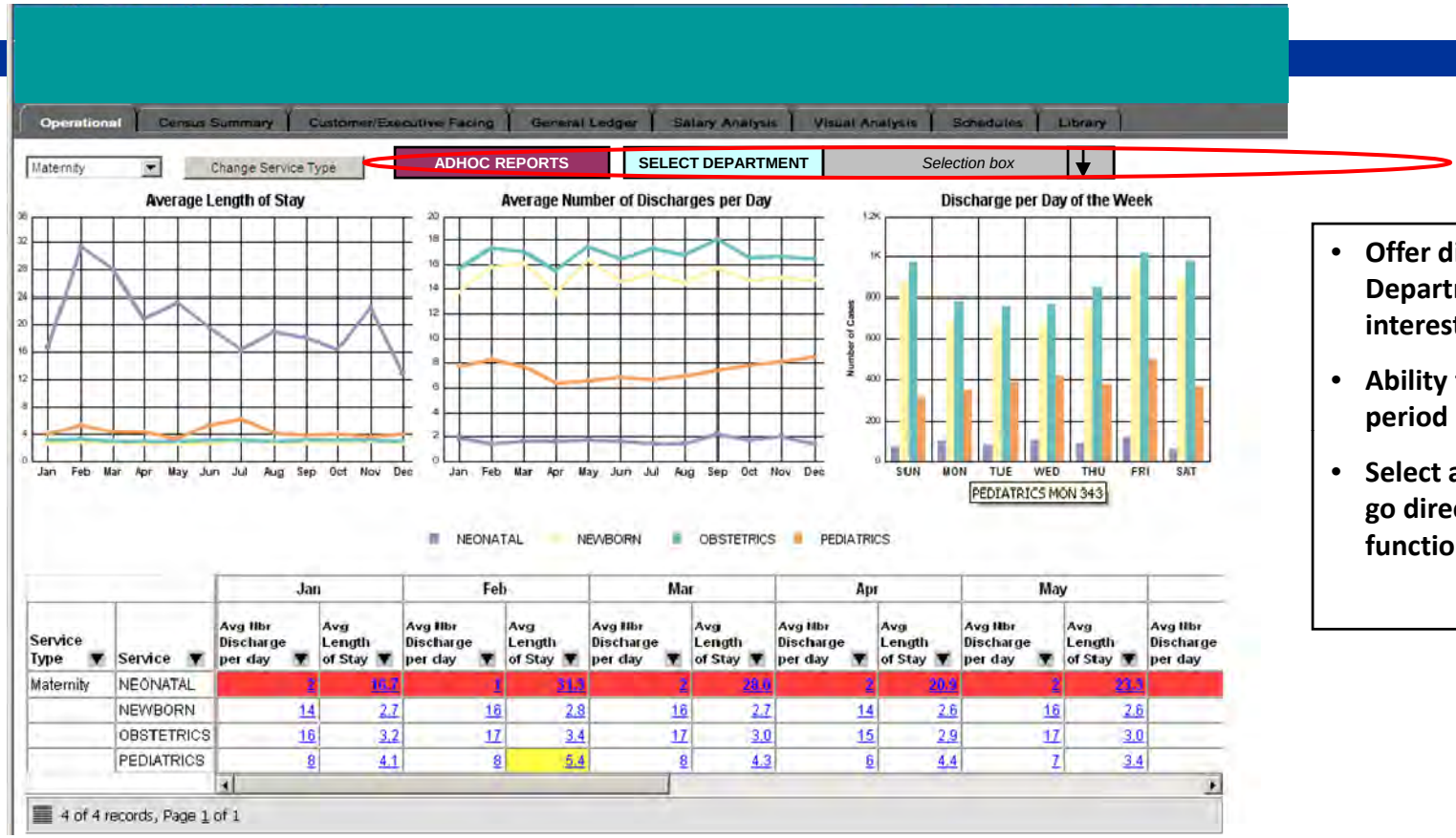
The BICC joins the skills, resources and experience of both Business and IT to achieve the common goal of the enterprise:

Fast, Accurate Business Intelligence.

It is a cross-functional team with specific tasks, roles, responsibilities and processes for supporting and promoting the effective use of business intelligence across the enterprise

BICC is about our Business Not Technology

Dashboard Example

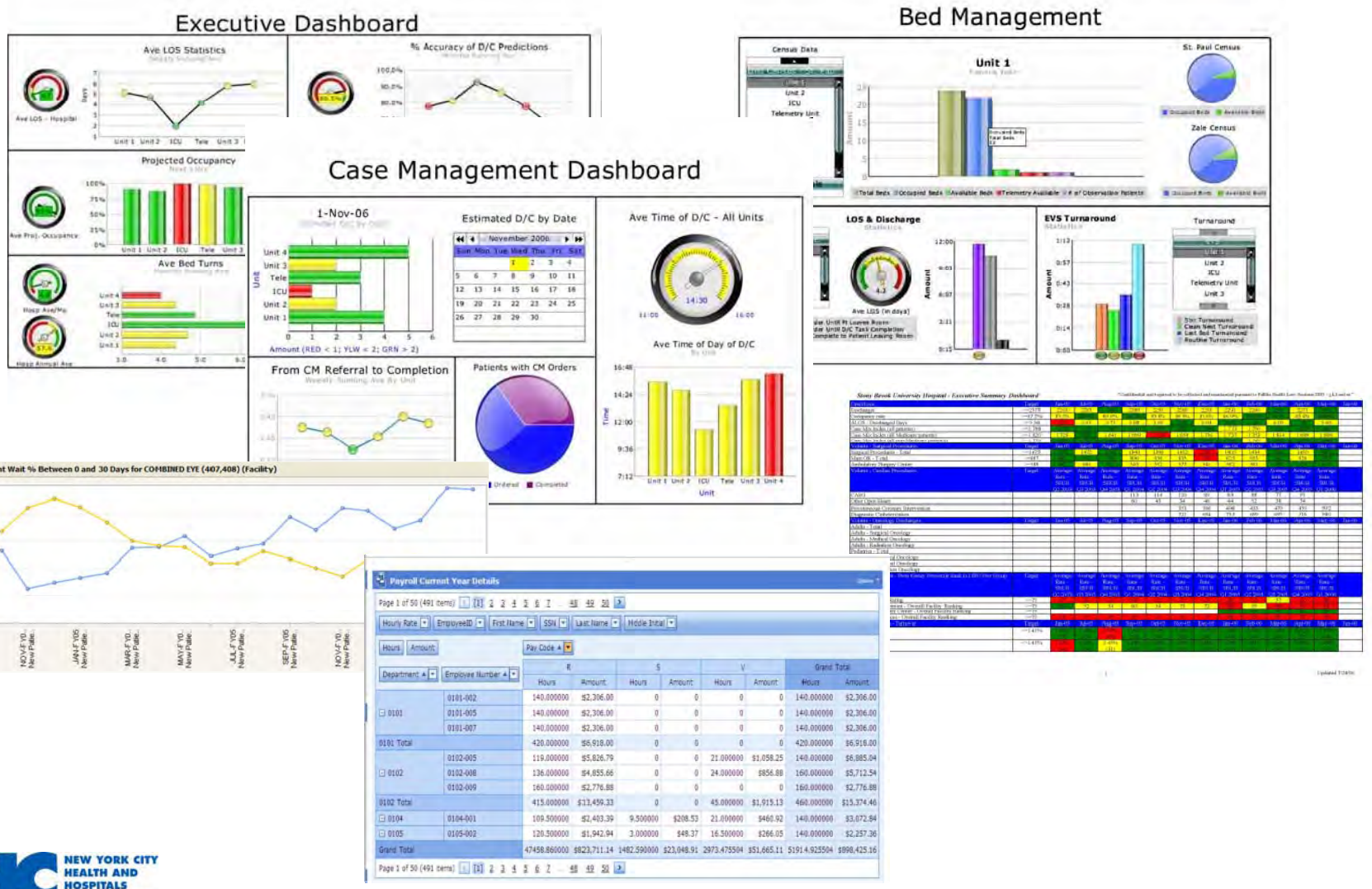


- **Offer direct access to Department/Service of interest**
- **Ability to change time period**
- **Select among tabs to go directly to functional areas**

Lines of Business, Key Areas of interest, can be delivered in customized menus, from any approach

FINANCIAL | OPERATIONAL INDICATORS | QUALITY INDICATORS | COMPLIANCE INDICATORS | PROVIDER METRICS
COSTS | TEACHING METRICS | FPA METRICS | INPATIENT OPERATIONS | RESEARCH INDICATORS
LOS | CORE MEASURES | MORTALITY | QUALITY SCORECARD | HOSPITALIST DATA
HOSPITAL OUTPATIENT | PATIENT SATISFACTION | COMPLIANCE | COSTS | NEW INITIATIVES | CREDENTIALING

Customized Dashboards



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