

**BOARD OF DIRECTORS MEETING**  
**THURSDAY, MARCH 26, 2015**  
A~G~E~N~D~A

**CALL TO ORDER - 4 PM**

**Dr. Boufford**

**Call for a Motion to Convene an Executive Session**

**Executive Session / Facility Governing Body Report**

- Coler Rehabilitation & Nursing Care Center
- Henry J. Carter Specialty Hospital & Nursing Facility

**Semi-Annual Governing Body Report (Written Submission Only)**

- Woodhull Medical & Mental Health Center

**OPEN SESSION – 5 PM**

**Dr. Boufford**

1. Adoption of Minutes: February 26, 2015

**Acting Chair’s Report**

**Dr. Boufford**

**President’s Report**

**Dr. Raju**

- **Information Item: HHC Accountable Care Organization (ACO)**  
**Presenter: Ross Wilson, MD, SVP/Chief Medical Officer-HHC**  
**Chief Executive Officer-ACO**

>>Action Items<<

**Corporate**

2. RESOLUTION authorizing the President to negotiate and execute a contract extension between the New York City Health and Hospitals Corporation and **Base Tactical Disaster Recovery, Inc.**, to provide expert consulting services for disaster recovery, project management, and filing claims for reimbursement from the Federal Emergency Management Agency (**FEMA**) for expenses incurred by the Corporation in connection with damages caused by **Super Storm Sandy**. The extension will be for a term of 12 months commencing August 1, 2015 through July 31, 2016 for an amount not to exceed \$2,500,000.

**Mr. Rosen**

*(Finance Committee – 03/10/2015)*

*EEO: Approved / VENDEX: Pending*

3. RESOLUTION authorizing the President to negotiate and execute a contract between the New York City Health and Hospitals Corporation and **Arcadis-US, Inc. and Parsons Brinckerhoff, Inc.** to provide professional architectural and engineering services to assist in the recover, reconstruction and hazard mitigation **of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital Center and other HHC facilities**, which were damaged as a result of the **Super Storm Sandy** disaster. The contract will be for a term of 12 months commencing October 1, 2015 through September 30, 2016 in an amount not to exceed \$5,000,000.

**Mr. Rosen**

*(Finance Committee – 03/10/2015)*

*EEO: Approved / VENDEX: Pending*

*(over)*



**BOARD OF DIRECTORS MEETING**  
**THURSDAY, MARCH 26, 2015**  
**A~G~E~N~D~A – Page Two**

<p><b><u>Committee Reports</u></b></p> <ul style="list-style-type: none"><li>➤ Community Relations</li><li>➤ Finance</li><li>➤ Medical &amp; Professional Affairs / Information Technology</li><li>➤ Strategic Planning</li></ul> <p><b><u>Subsidiary Board Report</u></b></p> <ul style="list-style-type: none"><li>➤ MetroPlus Health Plan, Inc.</li><li>➤ HHC Accountable Care Organization (HHC ACO)</li></ul> <p>&gt;&gt;Old Business&lt;&lt; &gt;&gt;New Business&lt;&lt;</p> <p><b>Adjournment</b></p>	<p><b>Mrs. Bolus Mr. Rosen Dr. Calamia Mrs. Bolus</b></p> <p><b>Mr. Rosen Dr. Raju</b></p> <p><b>Dr. Boufford</b></p>
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**NEW YORK CITY HEALTH AND HOSPITALS CORPORATION**

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 26th of February 2015 at 4:00 P.M. pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Dr. Ramanathan Raju  
Mr. Steven Banks  
Dr. Mary T. Bassett  
Dr. Gary S. Belkin  
Josephine Bolus, R.N.  
Dr. Vincent Calamia  
Dr. Herbert F. Gretz, III  
Ms. Anna Kril  
Mr. Robert Nolan  
Mr. Mark Page  
Mr. Bernard Rosen  
Ms. Emily A. Youssouf

Patricia Yang was in attendance representing Deputy Mayor Lilliam Barrios-Paoli in a voting capacity. Dr. Raju chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

Dr. Raju received the Board's approval to convene an Executive Session to discuss matters of quality assurance and potential litigation.

**FACILITY GOVERNING BODY/EXECUTIVE SESSION**

The Board convened in Executive Session. When it reconvened in open session, Dr. Raju reported that, 1) the Board

of Directors, as the governing body of Lincoln Medical and Mental Health Center, received an oral report and written governing body submission and reviewed, discussed and adopted the facility's report presented; 2) as governing body of Gouverneur Healthcare Services, the Board received an oral report and written governing body submission and reviewed, discussed and adopted the facility's report presented; and 3) as governing body of Queens Hospital Center, the Board reviewed and approved its semi-annual written report.

#### **ADOPTION OF MINUTES**

The minutes of the meeting of the Board of Directors held on January 29, 2015 were presented to the Board. Then on motion made by Dr. Raju and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on January 29, 2015, copies of which have been presented to this meeting, be and hereby are adopted.

#### **CHAIRPERSON'S REPORT**

Dr. Raju updated the Board on approved and pending Vendex.

Dr. Raju reported that on February 19, 2015, the 2015 Joint Commission Survey Leader, Ms. Gabrielle Townsend, joined Dr. Boufford, Mrs. Bolus, Dr. Gretz, Mr. Page and himself for an orientation. Dr. Boufford advised Ms. Townsend that, with respect to HHC's governance structure, the Board fulfills its responsibilities in a manner consistent with the relevant laws

and regulations, including conditions of participation under the Medicare program. In addition, the Board serves as governing body for each of the facilities operated by the Corporation.

Dr. Raju reported that the four hospitals to be surveyed by the Joint Commission this year are Coney Island Hospital, Kings County Hospital Center, Lincoln Medical and Mental Health Center, and Sea View Hospital Rehabilitation Center and Home.

#### **PRESIDENT' S REPORT**

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

#### **INFORMATION ITEM**

Roslyn Weinstein, Senior Assistant Vice President, provided the Board with a FEMA update. She stated that HHC had been awarded a FEMA Grant in the amount of \$1.72 million as a result of the damages to HHC facilities during super storm Sandy. The award is FEMA regulated, has many reporting requirements, and City Hall has an interest as to how the dollars are spent. In order to make sure that the funds are properly handled, HHC has engaged with two New York City agencies, the Economic Development Corporation and the Department of Design and Construction, to manage the construction contracts to meet FEMA requirements.

ACTION ITEMS

## RESOLUTION

2. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a **ten-year** extension to the contract with a joint venture known as the Consortium, consisting of **Sodexo HealthCare Services, US Foods, Inc. (formerly known as US Foodservice), and GNYHA Ventures, Inc.** The purpose of this extension is for the Consortium to continue to manage the Corporation's **food service operations and dietary workforce** and provide patient and resident meals at the Corporation's acute care and long-term care facilities. The Contract will run coterminous with an existing 25-year lease agreement of the Cook Chill production plant located on the Kings County Hospital Center campus. The plant shall continue to produce the Corporation's patient and resident food needs. The Contract extension shall be for an amount not to exceed \$361,105,676.

Mr. Antonio Martin, Executive Vice President and Corporate Chief Operating Officer, provided an overview of the Consortium's operational requirements and responsibilities. He stated that the objectives were to improve patient care and quality of food, to increase menu-variety options and patient satisfaction, and to improve employee working conditions and safety throughout the organization. The cost savings over the extension of the contract would be approximately \$14 million.

Ms. Carmen Charles, president of Local 420, and Ms. Barbara Ingram Edmonds of DC37 were given the opportunity to express their opinions on the proposal to extend the Sodexo contract.

Mr. Rosen moved the adoption of the resolution which was duly seconded and adopted by the Board with a vote of 12 in favor, with Mr. Nolan opposing.

**RESOLUTION**

3. Authorizing the President of the New York City Health and Hospitals Corporation to execute a three and one-half year **sub-lease agreement** with the **Healthcare Finance Group, LLC** for approximately 16,880 square feet of space at **199 Water Street, Borough of Manhattan**, to house **Delivery System Reform Incentive Payment Program ("DSRIP") staff** at an initial rent of \$460,000 per year or approximately \$27.25 per square foot to increase at a rate of 2.5% per year with the Corporation responsible for the payment of sub-metered electricity for a total commitment over the lease term exclusive of electricity of not more than \$1,173,144.

Ms. Youssouf moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

**RESOLUTION**

4. Authorizing the President of the New York City Health and Hospitals Corporation to execute a **five-year license agreement** with **Ronald McDonald House of New York, Inc.** for its use and occupancy of approximately 1,100 square feet of space on the fifth floor of the D Building at **Kings County Hospital Center** for the construction and operation of a Ronald McDonald Family Room for use by families of pediatric patients, with the occupancy fee waived and with the President having the authority to extend the license to include space at other facilities of the Corporation on a similar basis provided such extensions are reported to the Board.

Ms. Youssouf moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

**RESOLUTION**

5. Authorizing the President of the New York City Health and Hospitals Corporation to execute a **five-year license agreement** with the **Staten Island Ballet Theater, Inc.** for its continued use and occupancy of 5,000 square feet of space in the Laboratory Building to house administrative functions, dance instruction and hold performances at the **Sea View Hospital Rehabilitation Center and Home** with the occupancy fee waived.

Ms. Youssouf moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

#### RESOLUTION

6. Authorizing the President of the New York City Health and Hospitals Corporation to execute a **five-year revocable license agreement** with the **United States Department of Justice** for its continued use and occupancy of space to house communications equipment at the **Sea View Hospital Rehabilitation Center and Home** at an occupancy fee of approximately \$9,203 per year to be escalated by 3% per year.

Ms. Youssouf moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

#### RESOLUTION

7. Approving **amendments** of the **Bylaws of MetroPlus Health Plan, Inc.** to better enable MetroPlus to conduct its business.

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

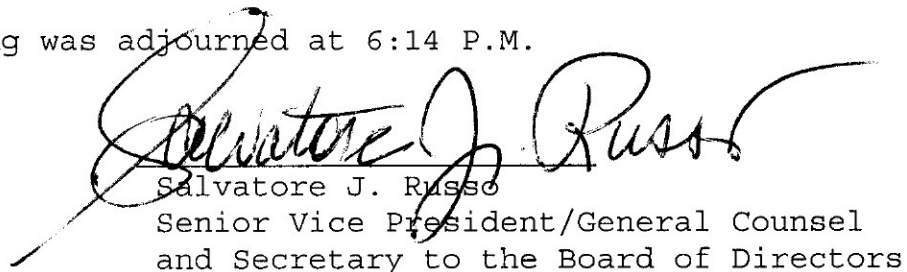
#### SUBSIDIARY AND BOARD COMMITTEE REPORTS

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



**ADJOURNMENT**

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:14 P.M.



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

# COMMITTEE REPORTS

## **Audit Committee – February 19, 2015** **As reported by Ms. Emily Youssouf**

Mr. Christopher Telano, Chief Internal Auditor, began by briefing the Committee on the audits currently being conducted by City and State Comptroller's Office. The first one is of the Navigant consulting billing practices. This audit started in July 2013 – they worked on it for about six weeks. Then we did not hear from them from September 2013 until we received a letter on January 28, 2015. The letter stated and I will quote "the audit has been terminated without issuing a report because there is no need to do so at this time". However, they did take the opportunity to make some observations and recommendations to improve our operations. Sal Russo and I had a conference call with them to discuss their concerns advising them that controls have been put in place and we have a more robust Audit Committee and internal auditing department to evaluate those controls to alleviate any fears that they might have. I followed that up with a letter reiterating what we discussed. That audit is closed.

Ms. Youssouf stated that that is good and asked if that seems to have satisfied them. Mr. Telano answered yes.

The second audit Mr. Telano continued on page three is of the Affiliation Agreement with Lincoln Medical and Mental Health Center and the Physicians Affiliate Group of New York (PAGNY). This audit is status quo – they are still obtaining information and have been ongoing since July 2013. On page four, another audit by the Comptroller's office, is also kind of on hold. This audit is the one that they requested reports with patient information and we declined due to confidentiality concerns. There were subsequent discussions between Wayne McNulty, HHC's Chief Compliance Officer, Salvatore Russo, Senior Vice President & General Counsel, the Comptroller's office and myself and we are waiting for some counterproposal on their part as to how we are going to resolve this. The last one on page four is the final audit of overtime cost by the state Comptroller's office.

Ms. Youssouf stated that let it be noted that Committee member and Acting Board Chair, Dr. Jo Ivey Boufford has joined the Audit Committee meeting. We are on page four in internal audits. Chris was giving us a rundown of where we are.

Mr. Telano continued and stated that the State Comptroller did a follow-up audit on their original overtime audit. There were three recommendations and due to the limited scope of their review, they did not consider the reduction in staffing that we had and those types of costs. The findings were partially resolved from their perspective -- it is a good audit and that was closed also.

Mr. Telano moved on to page five of the audits completed since the last meeting. The first one is of Patient Implantable Devices at Harlem Hospital Center. He asked the representatives to approach the table and introduce themselves. They did as follows: Ebone Carrington, Chief Operating Officer; Carmen Holt, Senior Associate Director; Franklin Armas, Manager; Lynette Faust, Senior Associate Director; Nelly Valentine, Senior Associate Director; Holly Gilbert, Hospital Police. Mr. Telano stated that I will go over the findings altogether and then you can address all three of them after I finish discussing them. The first one has to do with the improper billing of implantable devices. For example, we looked at 13 bilateral breast implant procedures and we noted that billing was for only implant instead of two. In addition, there was one other bilateral breast implant procedure that was not billed at all although it was coded. Overall 11 of the 13 bilateral breast implants procedures were not properly billed. We also found that one out of three Medipoint implant procedures was not billed at all. Keep in mind that our review did include looking at pacemakers, stents and gastric bands for arthroscopic procedures. It seems like it is just limited to those findings. We did not note any findings in the other procedures.

Committee Member Josephine Bolus, RN asked if we are past the time to bill for these. Ms. Faust answered that most of those procedures were cosmetic so they were self-pay. What happened was the patient paid in advance for both the implants as well as the procedures. So what we did after the findings were divulged to us, we added those implantables so we could adjudicate the account and bring it to a zero balance.

Mrs. Bolus asked if they requested the money from the patient. Ms. Faust responded no, we did not. Mr. Telano continued by stating that the second finding had to do with the lack of an inventory system regarding the implantable devices. In lieu of an inventory system, we had a representative from Cardinal monitor our inventory levels and then recommend the items that we should have and order from Cardinal. We paid them \$100,000 a year to perform this function. Ms. Holt stated that one thing we have done since then is we have requested an FTE, full time equivalent, which had been approved and that person will take over managing the inventory.

Ms. Youssouf asked does that mean you are going to bring the management of the inventory in-house and not have the contract with Cardinal anymore. Ms. Carrington responded correct. Ms. Youssouf then asked when that is effective. Ms. Carrington answered that the position has been approved and is being actively recruited for.

Ms. Youssouf said great and asked if they have the software behind for the inventory system. Ms. Holt responded that what we are currently doing is looking at our eCommerce system where we can generate reports related to our inventory that we currently have on hand. We are also working on the PXYSIS system, bringing that on board into the institution. We will be going to site visits to see how it is being used at another one of our facilities.

Mr. Telano continued stating that the last issue regarding this audit has to do with general access to the operating room suite. That area had various entries; some were accessible via swipe cards and others were accessible through the keypad code and one door was unlocked. There were 199 pages of individuals with access. My staff, when they were given a temporary ID card from Harlem, was able to access using this swipe card. Ms. Gilbert stated that since then the two doors that were in the back that were accessible by combination have been changed from combination access to card swipe, which is only accessible to authorized personnel. The front door that was unlocked has been secured and the amount of card swipe accessible parties has been limited to only authorized personnel.

Ms. Holt added that the authorized personnel list includes those who were approved by the Division Chiefs and we did not want to be restrictive because of the criticality of the area. Those physicians, nurses, members from pharmacy, administration and other approved personnel and as people are on board in each of these divisions; it has to be vetted by the department.

Ms. Youssouf asked if that is the procedure at other HHC facilities. Mr. Telano responded that I believe it is similar.

Ms. Youssouf then asked if this could be checked to be sure that is the similar procedure. Ms. Holt responded that we do know that is the case at our network facilities but I will reach out to other networks to see if that is a similar procedure.

Dr. Boufford asked if the self-pay cash payments may become more of a part of what we do over time and if you are satisfied that the fiscal and administrative procedures are in place to collect cash on-site at the facility. To which Ms. Zurack answered that we can take a look at that corporate wide in terms of cosmetic procedures.

Mr. Telano continued, the next audit that we completed was of the accounts payable process at MetroPlus Health Plan, Inc. and he asked the representatives to approach the table. He introduced himself as Wayne Hanus, Comptroller. Mr. Telano said that first issue found at MetroPlus is not making use of the automated approval system in which they use GHX to eCommerce to produce the purchase order, which is then paid in OTPS. There is a three-way match as a result of that, and the approvals are at the front end of the purchasing process. They also have chosen to use a handwritten voucher to obtain the approval after the invoice comes in instead of making use of the automated system.

Mr. Hanus stated that this procedure has been in place since the new system came onboard. The process that we have in place allowed us to ensure that there was uniformity in the signatures, the review and the attachments that were coming over to accounts payable because we had over 20 different departments submitting. We think the suggestion is certainly one worth pursuing if we can cut down on some of the paperwork or the waiting for that manual sign-off that you already have in the system. We are going to take a look at that and make a recommendation to the CFO by the end of March in terms of how we want to proceed with that.

Mrs. Bolus asked how long has the accounts payable been in that process. Mr. Hanus answered that it is probably ten years we have proceeded with this process. Ms. Youssouf asked why.

Mr. Hanus responded that that it is a methodology that the users of the system preferred because it allowed them to put together a package in a consistent manner and allowed us to review the items presented for payment.

Ms. Youssouf asked isn't GHX also a consistent manner? Mr. Hanus replied sure, that is why we want to look at it. We do have invoices that are coming from accounts payable that might be payable under a blanket order or those that might be just standard individual items and by doing it this way everything looks the same to the accounts payable unit coming in. Everything is processed in a similar manner to the different user groups.

Ms. Youssouf asked Ms. Zurack if she had any concerns about that. To which Ms. Zurack responded that I think when, in all fairness, you should have reviewed this internally and come to this committee with what you are doing. When you are saying you are going now recommend to your CFO, that is the MetroPlus CFO, this is the HHC Audit Committee it is sort of out of order.

Mr. Hanus stated that I understand – it is just the timing of the work going on in MetroPlus and we wanted to take the appropriate time to set something in motion.

Ms. Youssouf said that this report was issued January 5. Ms. Zurack added that she will have a conversation with Dr. Arnold Saperstein, Executive Director for MetroPlus – they should have their solutions before they come here. They are their own corporation so they do not have to follow our operating procedures and all our systems. This is just our recommendation that we think it would be better for them. It does not mean that they did not have a control; they could have used ours and had a better control. It is really more of a recommendation than a finding, but I do think it is inappropriate to come to the Audit Committee without having it resolved and just say we are going to talk about it and look at it. My recommendation would be in the future, MetroPlus comes here fully prepared.

Mr. Hanus said that that is fine – when we did set this up there was a lot of discussion with the central office folks and the team that was setting up GHX thought to be the best process for MetroPlus going forward. At that time, we thought it was the best way to ensure uniformity in the information being submitted and it has worked quite well. I think all we are talking about is a sheet of paper that is attached to the supporting documentation that comes over to accounts payable.

Ms. Youssouf stated her concern because it seemed as if it was being dismissed as nothing important. Even though MetroPlus is a separate organization, we are the only member and so we own it. If our internal audit department and our CFO believe that our system is better, I think it would be wise of you to actually look at it and try to match our system. Take this a little more seriously than a piece of paper – it is a little disconcerting.

Ms. Zurack commented that Chris Telano, in all fairness, is offering efficiency. It is not that they have a bad control. Mr. Telano said that it is an efficiency matter and it is over controlled. Basically the process is too long and that is the way HHC has it set up.

Ms. Zurack said that in the interest of newness, Wayne Hanus is a terrific controller. Typically, John Cuda, CFO and the procurement person should have come to this.

Ms. Youssouf added that it would be great at perhaps the next Audit Committee meeting somebody comes back and says you are in the process of doing it or whatever the solutions is. To which Mr. Hanus said that we can do that.

Mr. Telano continued by stating that the other finding is lack of proper documentation related to two consultant payments. One was paid without a contract in place and another one was being paid without supporting time sheets. I believe they were resolved.

Mr. Hanus said that they were resolved. The one physician without the contract in place we no longer use the services and with regard to the physician that was submitting the invoice without the time, the individual is actually performing those services on-site. It was an oversight that a time sheet was not prepared and that individual has been preparing time sheets for several cycles.

Mr. Telano said that in the interest of time, we will not be calling anyone up to the table from Coney Island and Elmhurst; they have similar findings in which the unannounced count, surprise counts, revealed discrepancies around 20 percent. At Elmhurst, it equaled \$2,400 in differences. There was also commingling of inventory at the pharmacy in Coney Island – there were some wholesale acquisition costs items intermingled. At Elmhurst in the medical surgical, there was Hemodialysis supplies commingled within the inventory. To the best of my knowledge, everything has been resolved and they took the necessary steps during the course of this audit.

Mr. Telano stated that that concludes his presentation.

Ms. Youssouf asked if there were any questions for Mr. Telano. She then turned to Wayne McNulty for the compliance update.

Mr. McNulty saluted everyone and stated that on page three of the corporate compliance report, section one, the first two topics I would like to discuss are required certifications that HHC must implement in order to participate in the Medicaid program. The first certification is the compliance program certification. On December 22, 2014, HHC president and chief executive officer Dr. Ramanathan Raju certified through the Office of the Medicaid Inspector General's website certified that HHC had an effective compliance program. Several elements must be met in order to certify that you have an effective compliance program: 1) written policies and procedures; and 2) having a designated compliance officer. There are several other elements listed above that include a non-intimidation and non-retaliation policy for good faith reporting and participation in a compliance program. The second certification was the certification with the Deficit Reduction Act of 2005. The Deficit Reduction Act requires HHC to have policies and procedures to detect and deter fraud, waste and abuse and policies and procedures related to the False Claims Act and those policies and procedures must be set forth in any employee handbook at any HHC facility.

On page seven, there is an overview of some of the compliance programs, DRA requirements. On December 29, I certified that HHC is in compliance with the Deficit Reduction Act in the Office of the Medicaid Inspector General website. Also on page seven, there is a report on HHC's compliance with the HIPAA Security Rule Risk Analysis requirements. Pursuant to the Health Insurance Portability and Accountability Act of 1996, better known as HIPAA, and its Security Rule, which is its implemented regulations, HHC is required to perform a risk assessment program. The purpose is to correct, prevent, detect, contain and correct any security violations.

On page eight, one of the key elements of a risk assessment program is the performance of a risk analysis. Under the Security Rule, HHC is required to conduct an accurate and thorough assessment of the potential risk and vulnerabilities to the confidentiality, integrity and availability of electronic protected health information throughout HHC. Page 9 discusses risk assessment – at-risk assessment may be performed in a number of ways. There is no particular methodology required. However, there are eight key steps that must be performed to be in compliance with the Security Rule. One, is you have to identify the scope of the analysis; two, gather data and information; three, identify and document potential threats and vulnerabilities. By threat means that any action that if it occurred would put the confidentiality, integrity of our information at risk and vulnerability in the likelihood of that threat occurring.

Moving to four – assess current security measures, determine the likelihood of threat occurrence, determine the potential impact of threat occurrence. Impact meaning it could be financial impact, legal impact or reputational impact. Then the last one is identify security measures and finalize documentation. We did a review of HHC's compliance with the Security Rule risk analysis requirements under HIPAA and we determined that one, the inventory of HHC's information systems and applications that access, house or transmit electronic protected health information is a work in progress and therefore is not comprehensive now. Although, HHC's Enterprise Information Technology Services has taken numerous and significant measure to enhance and maintain the confidentiality, integrity and security of HHC's information systems; including the formation of information governance and security program, the implementation of security controls and a performance of formal risk analysis on a handful of applications, it appears that measures must be taken by information technology to fully satisfy the extensive risk analysis and implementation measures required under the Security Rule.

Our recommendation is to identify inventory as a priority, all HHC systems and applications that are housed and transfer electronic protected health information. Provide a written schedule over a 12-month schedule by which all systems will be inventoried and have a completed risk analysis. Provide a written schedule over a 12-month schedule that would look at the other standards of the security rule to be assessed. Provide a written schedule under the Security Rule to document the reasons why specific items – let me take a step back. Under the Security Rule, there are two types of requirements, addressable requirements and requirements that are just plain required in the Security Rule -- meaning, that the corporation does not have the option to forego those requirements. The addressable requirements, if you perform a risk analysis and that risk analysis shows particular areas of low vulnerability you do not have to follow those particular regulations for that area. However, you have to perform a risk analysis first before you can make that assessment. Immediately begin a risk analysis for the top 25 high-risk applications. Inventory all remediation recommendations resulting from any completed risk analysis and then ensure that, regardless of the methodology used to perform the required risk analysis, that you document the eight steps that I mentioned earlier.

We recommend a practice guide – that IT take a look at the National Institute of Standards and Technology and their risk assessment. Also, look at the HIPAA guidance on risk analysis under the HIPAA Security Rule. As a follow-up, the findings that I just provided have been communicated to EITS leadership. At this time, we are awaiting management's response to this report, which will be provided by Bert Robles, Senior Vice President, Information Services. We expect that we will have Information Services come to the Audit Committee in April to provide a response to our report.

Ms. Youssouf asked if that puts us at any risk between now and April. To which Mr. McNulty responded that if we have a system that transmits and houses EPHI and we are not aware that vulnerability exists then that could put us at risk. We have a significant amount of security controls in place, and they have put forward a security governance program over the past several years and they have performed the risk analysis on a handful of the very high-risk applications. Now additional measures I believe are going to be necessary to be in full compliance with the Security Rule.

Mrs. Bolus asked did the warehouse fire have any effect on that. Mr. McNulty answered that I will discuss the fire in executive session.

Moving along to section four, Compliance Reporting Index for the Fourth Quarter, Calendar Year 2014 October 1 to December 31, 2014. There were 136 reports that we have received at the Office of Corporate Compliance. One of which was a priority A report. We had 85 priority B reports. The remaining were C reports. Some notable reports are ongoing investigations and I will discuss that in executive session. The Privacy Reporting Index for the Fourth Quarter, Calendar Year 2014 October 1 to December 31, 2014 -- we received 30 complaints in our HIPAA tracking system. We determined seven were breaches of health information, the majority of the breaches occurred because wrong documentation was sent to the wrong patient. One breach occurred at Bellevue Hospital; it involved the unauthorized access of a patient's medical record by

numerous workforce members. The patient was notified of this and the Department of Health and Human Services, which receives notification of breaches of PHI were notified of this incident. Since that matter is still an ongoing investigation, I will provide a more detail in executive session.

Dr. Boufford asked in the incident reporting, you used the word complaints. Is there a distinction there and any kind of incentive for people to be sort of reflective and self-critical about what is going on or did it come up because a third party cites a problem. Mr. McNulty responded that the majority is because a third party notifies us that information was breached. We do have information where the HHC staff members will notify us and say that X, Y and Z occurred. The staff members have been forthcoming when they notice that there was a breach based on inadvertent error. The majority of times it is the patient because the patient is receiving a notification of another patient's name on it and we were unaware that we have sent that out until we receive a notice from the patient.

Dr. Boufford stated that I am curious about how much self-policing there is. There is opportunity there in terms of the way the procedures are set up. It sounds like you are doing that. Mr. McNulty said absolutely, we take that into account as far as our disciplinary policies. Monitoring of Excluded Providers, we have not received or uncover any reports of this group since the last time the Audit Committee convened in December 2014.

On page fifteen, I will report some ongoing compliance matters to the Audit Committee in April 2015. One is the status of our revision of our Operating Procedure 50-1, which is the operating procedure that governs the Corporate Compliance Program, revision of our Principles of Professional Conduct and HHC Corporate Compliance Plan. With regard to Compliance best practices, they recommend within every several years that you revise your compliance policies and procedures. The second is we would like to review our findings of HHC's compliance with the HIPAA business associate agreement requirements and also vendor management activities and CMS regulatory requirements for contractors. Last, we will discuss our compliance and privacy training activities in our corresponding compliance rates.

Ms. Youssef stated that that is good news about excluded providers. It has been a while – that is a great improvement.

Mr. McNulty asked the Audit Committee if they had any questions and then concluded his Report.

Ms. Youssef thanked Mr. McNulty, and then indicated that the Committee was going into Executive Session.

### **Capital Committee – February 19, 2015** **As reported by Ms. Emily Youssef**

#### **Senior Assistant Vice President's Report**

Roslyn Weinstein, Senior Assistant Vice President, Office of the President, announced that the Economic Development Corporation (EDC) had been selected as Contract Manager for upcoming Federal Emergency Management Agency (FEMA) funded projects. She noted that EDC was known for liking Contract-at-Risk work, and with that in mind she looked forward to a robust, on time, on budget, FEMA program with the \$1.72 billion that the Corporation had received. She said the first kick-off meeting had been held, with the Office of Resiliency, the Office of Management and Budget (OMB), the EDC, etc. She explained that City Hall was very interested that HHC did this correctly, but HHC was even more interested in doing it correctly. She said that the RFP for architectural services was being reviewed for the new Coney Island Critical Service Building, and a Value Engineering (VE) program had been scheduled with OMB for the end of March to ensure that the money was spent right, and the scope was right.

Ms. Youssef said she was glad that EDC was being used again because they had previously done a good job for HHC.

Ms. Weinstein then advised that HHC had gotten preliminary approval for \$110 million for Capital programs, and the Corporation would be finding out which projects were funded but it included EPIC and a number of tier one requests. She noted that the Corporation would be hearing more sometime in April when the executive budget was released.

She noted that the agenda included two license agreements for space Sea View Hospital Rehabilitation Center and Home, a lease agreement for office space for the the Centralized Services Organization (CSO) for the Delivery System Reform Incentive Payment (DSRIP) program at 199 Water and the space for a Ronald McDonald House family room at Kings County.

That concluded Ms. Weinstein's report.

#### **Action Items:**

*Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year license agreement with the Staten Island Ballet Theater, Inc. (the "Licensee") for its continued use and occupancy of 5,000 square feet of space in*

*the Laboratory Building to house administrative functions, dance instruction and hold performances at the Sea View Hospital Rehabilitation Center and Home (the "Facility") with the occupancy fee waived.*

Angelo Mascia, Executive Director, Sea View Hospital Rehabilitation Center and Home, read the resolution into the record.

Ramanathan Raju, MD, asked that Mr. Mascia outline the value of having the licensee on site at the facility. Mr. Mascia explained that the organization had been on site for 14 years and had made a number of Capital investments including; new roofs, heating updated, valve replacements, new interior radiators, and more, work that HHC would have had to preform had they been occupying the space themselves. Mr. Mascia noted that the group also enhanced cultural and educational services of the community, and preformed once a month for the residents of Sea View and once a year provided tickets for their holiday show at the College of Staten Island.

Ms. Youssouf said that she believed it was a worthwhile partnership that was greatly appreciated by the residents.

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

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

*Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to execute a five year revocable license agreement with the United States Department of Justice (the "Licensee") for its continued use and occupancy of space to house communications equipment at the Sea View Hospital Rehabilitation Center and Home (the "Facility") at an occupancy fee of approximately \$9,203 per year to be escalated by 3% per year.*

Angelo Mascia, Executive Director, Sea View Hospital Rehabilitation Center and Home, read the resolution into the record.

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

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

*Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a three and one-half year sub-sub lease agreement with the Healthcare Finance Group LLC (the "Sub-Tenant") for approximately 16,880 square feet of space at 199 Water Street, Borough of Manhattan, to house Delivery System Reform Incentive Payment Program ("DSRIP") staff at an initial rent of \$460,000 per year or approximately \$27.25 per square foot to increase at a rate of 2.5% per year with the Corporation responsible for the payment of sub-metered electricity for a total commitment over the lease term exclusive of electricity of not more than \$1,173,144.*

Christina Jenkins, MD, Senior Assistant Vice President, Medical and Professional Affairs, read the resolution into the record.

Dr. Jenkins explained that in December of 2014 the Board of Directors had granted permission to establish the Centralized Services Organization (CSO), essentially the not-for-profit equivalent of a wholly owned subsidiary. The CSO worked in service to the PPS which was comprised of HHC and its partners, to ensure that it performs as it should. She said that there was a large body of work and a team of people that needed to be in place, and interacting regularly to design and implement IT projects. There were notable work-streams that cross the City; workforce strategy, health literacy, Information Technology (IT) connectivity strategy, etc., for which there was currently a team of four, that would grow in numbers. She advised that there was no room to house the group in current office space so 199 Water Street was identified and provided proximity to Corporate Offices at 160 Water Street and 55 Water Street.

Mr. Page asked who the Healthcare Finance Group was. Dr. Jenkins said they were the subtenant. Mr. Page asked if they were a for profit organization. Ms. Jenkins said she believed so.

Mrs. Bolus asked when the grant money would be coming in and whether it would be in time to pay the first months' rent. Dr. Jenkins said the timeline was still a little fuzzy but they should know the award amount in mid-March, and funds should begin to flow no later than June. She said the lease would be available to sign in March, although the Corporation may sign at a slightly little later. Mrs. Bolus asked if rent money would be needed prior to grant funding coming in. Dr. Jenkins said approximately one month rent, maximum.

Ms. Youssouf asked if the space would be needed should no grant money come through. Dr. Jenkins said she was sure that money would be awarded.

Ms. Youssouf asked if the space would be available for our partner organizations to utilize. Dr. Jenkins said there would be some room available and conference rooms would be shared for workgroups.

Mr. Page asked for an explanation of that statement. Ms. Youssouf explained that the Performing Provider System (PPS) was comprised of a number of organizations that work in partnership and HHC was the leading organization and therefore needed space not just for ourselves but where the PPS could come together. Mr. Page asked if the partner groups had their own funding. Dr. Raju explained that all money would flow through HHC. The rent to support CSO operations would come out of DSRIP payments. Mr. Berman added that in all agreements made with the partners, before they can touch any of the money, expenses such as rent, would be paid. Mr. Page asked who would be keeping track of the money, not excluding, whether a fellow not for profit is utilizing the space, in which case he felt that meant the funds were funding the other organizations and not HHC. Ms. Youssouf reiterated that HHC was the lead organization, leading the charge and the first stop in the money flow.

Dr. Jenkins said she expected an unprecedented level of scrutiny and oversight. She explained that the space was comparable with other HHC Corporate Offices. Mr. Page said he wasn't questioning the need for the space or the appropriateness of the space but he was bothered somewhat by the first item on the agenda. He said that he felt that if the Corporation were authorizing a monetary contribution to a not-for-profit ballet in Staten Island then it would be questionable, whereas making space available without cost has become a pattern. He said he understood that in this case it would be HHC space that would be shared with our partner organizations as needed, and not HHC setting up office space for our partner organizations. Dr. Jenkins said yes, this is our office space, we are not setting up space for other people, but it will likely be shared at times.

Dr. Raju explained that the CSO was contracted to provide money to the various groups and administrative costs were included. He said HHC was acting as leader, or in some way as the Board. Dr. Jenkins reiterated that the PPS was a collection of partners.

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

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

*Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five-year revocable license agreement with Ronald McDonald House of New York, Inc. (the "Licensee") for its use and occupancy of approximately 1,100 square feet of space on the fifth floor of the D Building at Kings County Hospital Center ("KCHC") for the construction and operation of a Ronald McDonald Family Room for use by families of pediatric patients, with the occupancy fee waived and with the President having the authority to extend the license to include space at other facilities of the Corporation on a similar basis provided such extensions are reported to the Board.*

Joe Schick, Executive Director, The Fund for HHC read the resolution into the record. Mr. Schick was joined by Christina Powell, Director, The Fund for HHC.

Ms. Youssouf asked for an outline of the arrangement and expressed excitement. Mr. Schick said this was the first public hospital to receive a Ronald McDonald House Family Room, although there were two others in the State, one in Albany and one at Stoney Brook, and one projected to open in the next year or so at New York University (NYU) Hospital. In every case, and there are hundreds within the United States and abroad, the organization works with the facility to design and build according to HHC codes and standards and make the space available to families of children in our facilities. He explained that the room would be staffed by volunteers and everything would be done in coordination and collaboration with the facilities. He said HHCs only obligation would be the day to day maintenance that would be handled regardless of the organizations occupancy.

Ms. Youssouf asked if construction would be at the organizations expense. Mr. Schick said yes. Dr. Raju asked what they provide. Mr. Schick said it was intended to be a space for rest and respite, a home away from home for the families of children undergoing treatment. He explained that while child received treatment the family would have a place to go where there would be a shower, couches, televisions, and refreshments.

Mr. Page asked if Mr. Schick knew how the relationship between NYU and Ronald McDonald House was drafted. Mr. Schick said he did know that NYU was not being provided payment for the space and they were also waiving any occupancy fees.

Mr. Page asked about the services that HHC would be providing; heat, housekeeping, etc. Mr. Schick explained that those services are ones that would be provided to the space regardless of the occupancy of Ronald McDonald House. They were regular daily maintenance tasks that are performed at present.

Mr. Page asked if Ronald McDonald House operated any sites in New York City, outside of hospital settings. Mr. Schick said yes, there was a central facility on East 73rd Street that houses families that come from outside of the City with children receiving treatment within the City, primarily suffering from Cancer. The site had 84 rooms that were nearly always at full capacity.

Dr. Raju noted that the smaller sites were a new idea in New York for Ronald McDonald House. Mr. Schick said yes, new in New York, but there were 176 worldwide.



Mr. Schick said he looked forward to the addition of family rooms at other facilities over the course of the agreement. Ms. Youssouf said it sounded like a terrific idea and the clientele that HHC serves would most definitely benefit from them.

Mr. Page asked if they were obligated to continue to run the room for the course of the five year license. Mr. Berman advised that any license agreement could be terminated on prior notice so it was possible that they could terminate the agreement, however, the enhancement to the space would be HHCs so a termination of their role would be in supplying the volunteers and refreshments, but the enhanced space would be a benefit to the facility.

Mr. Schick added that the building of this family room represented a relationship that went back nearly three (3) years between the facility and the Ronald McDonald House, as they have put on events, and worked with pediatric leaders and local administration.

Mrs. Bolus asked about security at the site. Mr. Schick said the nurse's station would be the control. That is where access would be granted.

Mrs. Bolus noted that HHC had a program that issued Metro Cards to those in need and she recommended that it be researched. She expected that those utilizing the room may also benefit from the Metro Card allowing them to travel to and from the facility. She also requested that local hotel/motels and their rates be available. Mr. Schick said he would look into that.

Mrs. Bolus advised that the Johnson & Johnson Corporation had a similar program, she believed was operating in New Jersey, and recommended that Mr. Schick take a look at that space. Mr. Schick said he would do that.

Dr. Raju thanked Ronald Mc Donald house for the opportunity. Ms. Youssouf expressed excitement and Mrs. Bolus agreed, noting that the group is welcome to look for space at other HHC facilities.

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

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

## **Information Items**

### *Project Status Reports*

Being that there were no projects in delay by six (6) months or more there were no delay reports provided.

## **Finance Committee – February 10, 2015**

### **As reported by Mr. Bernard Rosen**

#### **Senior Vice President's Report**

Ms. Marlene Zurack informed the Committee that the report would include three items. The first of which included the announcement of HHC's Federally Qualified Health Center approval by the Health Resources and Services Administration (HRSA) as "Look-Alike status." This was a major achievement for HHC that had been in progress for a number of years under the guidance of Ms. LaRay Brown, Senior Vice President, Intergovernmental Relations, Corporate Planning and Community Health and the Corporate Planning staff and other key HHC staff. In anticipation of this approval, HHC in its Financial Plan included \$30 million in additional revenue for wrap-around payments that the FQHC will receive as part of the Medicaid managed care payment structure which is approximately \$130.00 per visit and also additional benefits in Medicare rates; 340B pricing and malpractice coverage.

HHC President, Dr. Ram Raju extended thanks to Ms. Brown and staff and also to Mr. Aviles who had led the efforts in obtaining this status.

Ms. Zurack, moving to the next item stated that the January Financial Plan for the FY 16 budget had been announced by the Mayor's office. Some of the highlights relative HHC included the major changes that were included in the November Plan that were incorporated into the January Plan, notably, \$20 million in FY 15 for EBOLA expenses at Bellevue and collective bargaining adjustments. The major adjustment for HHC relates to capital whereby the City has added \$110 million for capital for several projects, EPIC, add-on for revenue cycle, other additional costs for the EPIC project, boiler plant, fuel tanks upgrades, electrical systems upgrades and window replacements at Metropolitan Hospital and some other small infrastructure upgrades. The last item in the report, HHC's cash status was at 28 days of cash on hand, a significant improvement from last month and the projected year-end cash balance is \$550 million. The reporting was concluded.

## Key Indicators/Cash Receipts & Disbursements Reports

Ms. Krista Olson reported that utilization for the current FY 15 compared to last year on a month to month basis, December 2013 and 2014 for the first time this FY there is an increase in all three areas, acute discharges, ambulatory care visits and nursing home days. Year-to-date (YTD) there is a slight decline in acute care discharges down by 2.8%; however, due to the increase in December 2014 it is lower than it has been, 3.6% last year excluding Coney Island it was 6.5%. On the ambulatory care side, overall visits are down by 1.3% compared to last year for the same period, slightly better than last month 2.4% decrease. The D&TC visits are down by 2.0% compared to 3.7% last month. However, East NY was up by 9.1% which is a positive trend.

Dr. Raju commented that it was a significant trend and asked Julian John, CFO, Central Brooklyn Network to share with the Committee what the Network had done to achieve that positive outcome and if possible to have that replicated across the Corporation.

Committee Member, Mark Page asked if another center/facility had closed that contributed to the increase.

Mr. John stated that there was a change in leadership and since that change under the new administrator and the medical director the focus has been on access to care and improving productivity. There have been 48-hour pre-visit calls implemented and in behavioral health there was a change in how visits were closed and are now being done more timely.

Mr. Page asked for clarification of improving productivity and how that has impacted the change.

Mr. John stated that in prior years the facility has observed that the number of patients in the clinics was less than anticipated and that the number of patients per provider was also lower than expected. Improving the time and flow in the clinics added to more patients coming in.

Dr. Raju added that the waiting time has improved and patients do not have to wait a long time to see the doctor and that has enabled the facility to see more patients. The flip side of this trend at East NY is at Renaissance whereby the visits are down. Caswell Samms, CFO, Generation Plus/Northern Manhattan Network stated that Renaissance Health Care Network has been addressing several issues that relate to the relocation of the clinics that has put it in a more competitive environment. The other issue relates to staffing, whereby there were recent retirements that included three practitioners in the Medicine clinic and two practitioners in pediatrics. These were some long standing employees who were being rolled over to become PAGNY employees. A meeting was scheduled with PAGNY on the issue. Consequently, those vacancies have had a significant impact on the volume. In the interim a panel capacity analysis was conducted to see where there might be an opportunity to increase the panel size of some of the physicians.

Dr. Raju added that Mr. Martin would follow-up with PAGNY on that issue to ensure that it is addressed.

Ms. Olson completing the reporting stated that nursing home days were up by 2% and that the LOS corporate average was up by 5%.

Dr. Raju stated that Coney Island LOS was above the corporate average at 6.7% and asked Paul Pandolfini, CFO, Southern Brooklyn/Staten Island Health Network to address the issue.

Mr. Pandolfini stated that Coney Island treats a large number of Medicare patients and elderly patients with the average age on the inpatient side of 51.4 years compared to 40.5 corporate wide. The average age of Coney Island patients is 76.9 years compared to 70.4 corporate wide. These patients are elderly and frail and are more clinically challenged and are 38.4% of the facility's Medicare population which poses some challenges in treatment. Coney Island has 34% more med surg beds than the other acute care HHC facilities and the LOS for the acute patient is a critical issue. Based on a review of the issue it appears that there is room for improvement in discharging patients on the weekends. Only 7.2% of the discharges occur on Sundays and 8.7% on Saturdays. Corporate wide it is 8.4% and 10.1%. A review of best practices, Lincoln, Elmhurst and Woodhull do well in this areas and Coney Island is reviewing those best practices to improve the process. A better tracking system is also needed. It is a very complex situation and the facility is making every effort to address it. Additionally, DISRIP is expected to assist in this process of reducing the LOS without compromising patient care through premature discharges and readmission.

Mr. Page asked if there is an issue with where the facility discharges the patients and whether specific resources have been considered to assist in addressing the problem

Mr. Pandolfini stated that some nursing homes are problematic and families are not always cooperative. The facility is addressing the issue with the appropriate clinical staff and the medical director and there are a number of options that are being explored such as using the 4th Year resident to assist in the effort.

Dr. Raju thanked Mr. Pandolfini for his overview of the actions taken by the facility and the care in which the facility is taking in addressing this issue in conjunction with ensuring the safety of its patients. Central office will continue to work with the facility on resolving this issue.

Ms. Olson in finalizing the report stated that the CMI was up by 3% compared to last year.

Mr. Covino before continuing with the reporting informed the Committee that HHC is currently in the process of implementing an FTE "right sizing" initiative to benchmark global FTES to workload across the Corporation. Global FTEs include all FTEs, overtime, allowances, temp agency services and affiliation. This will be implemented over the next eighteen months with the expectation of reducing global FTEs by 735 out of a baseline of 45,000. As of December 2014, FTEs were up by 292 with significant increases at some of the facilities. Bellevue was up by 29 nurses due to a reduction in the use of agency nurses. To-date the savings total \$2.6 million in cost netted against the hiring of the nurses the savings equate to under a \$1 million. Additionally, there was a transfer of nine dental residents from Coney Island to Bellevue and eleven medical record coding specialists were hired. Lincoln is up by 65 FTEs due to staffing for a new emergency department and psych units. Woodhull is up by 25 FTEs which is within the benchmark target that is slightly under. Elmhurst and Queens are 103 over the target; however, it is a network-wide initiative to convert agency staff to regular staff employees. Enterprise Information Technology (EIT) was up by 25 FTEs which was in compliance with the budget for staffing the EMR program. Receipts were \$83 million worse than budget to-date while disbursements were \$39 million worse than budget. Cash receipts were \$3 million better than last year due to a \$73 million increase in DSH payments through December 2014. Medicare and Managed care Medicare were up by \$7 million compared to last year due to an increase in the DSH component of the Medicare rate last year. Those two payments were offset by a delay in the timing of a SLIPA pool payment whereby last year \$90 million was received in November this FY 15 it was received in January 2015 which is reflected as a reduction against last year. Additionally, \$100 million in MetroPlus risks pool payments were received compared to \$150 million received last years for the same period; however, there is another \$65 to \$70 million that will be available to HHC to drawdown by the end of the current FY 15. Expenses were \$164 million higher than last year due to an increase in PS costs relative to CB payments of \$98 million with a \$14 million increase in allowance cost and the balance due to increase in FTEs. Fringe benefits were \$51 million less than last year due to the timing of those payments last year whereby a \$35 million payments was made in December last year but was made in January 2015 this FY 15. Also last year a non-recurring health insurance a non-recurring payment was made on behalf of prior years. OTPS expenses were up by \$64.7 million due to an increase in pharmaceutical costs related to the 340B policy changes of \$20 million year to date. Professional series were up by \$18 million and purchased services by \$11 million. Affiliation payments were up by \$30 million due to a change in the payment methodology from monthly to biweekly. Overall the total cost will increase by 4% over last year's baseline. Comparison of actuals to budget, receipts were down by \$77 million due to a reduction in workload and were up by \$13.5 million and other receipts were down by \$10.2 million due to appeals and settlements, whereby the difference for Medicaid fee-for-service receipts are being paid at 98% and the 2% reduction balance is being reflected in the appeals and settlements which is expected to be recovered by the end of FY 15. Expenses in all categories were within budget with the exception of OTPS which was \$43 million worse than budget due to pharmaceutical costs. The reporting was concluded.

#### **Action Item:**

*Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a ten-year extension to the contract (the "Contract") with a joint venture known as the Consortium, consisting of Sodexo HealthCare Services, US Foods, Inc. (formerly known as US Foodservice), and GNYHA Ventures, Inc. The purpose of this extension is for the Consortium to continue to manage the Corporation's food service operations and dietary workforce and provide patient and resident meals at the Corporation's acute care and long-term care facilities. The Contract will run coterminous with an existing 25-year lease agreement of the Cook Chill production plant located on the Kings County Hospital Center campus. The plant shall continue to produce the Corporation's patient and resident food needs. The Contract extension shall be for an amount not to exceed \$361,105,676.*

Mr. Antonio Martin, Executive Vice President, Corporate Chief Operating Officer, informed the Committee that HHC executed a contract in 2005 with Sodexo HealthCare Services, US Foods, Inc. and GNYHA ventures (the Consortium) with the purpose of improving the quality of the food, patient care and increase the variety of food options; increase patient satisfaction; standardize food policy and procedures throughout the Corporation to comply with regulatory requirements; optimize facility staffing plan, assure regulatory compliance; reduce and contain dietary operating costs throughout the term of the contract. Some of the major achievements include: implemented a 21-day menu cycle which increased the food choices for all acute care and long term care facilities; instituted corporate wide formulary for nutritional supplements as established by clinical committee; instituted a cook chill model and installed equipment throughout HHC facilities; modernized the cook chill plant; standardized policies and procedure food delivery; standardized reporting systems for cost controls and financial analysis resulting in real time information; assessed staffing levels resulting in identified workflows that improved direct and indirect patient care, patient safety and employee safety; established an optimum staffing plan of 934 FTEs; achieved an aggregate cost savings of \$57 million during the first ten year term of the contract.

Mr. Martin stated that to better address the concerns of the patients a committee was developed and the recommendations included: a new hot breakfast option to replace continental breakfast and improve the patient experience that was not previously done; enhancement of patient safety and regulatory compliance by deploying CBORD, a clinical software technology that assures patients receive the doctor's dietary order; the contract guarantees a staffing plan of 947 FTEs; renovation of the CCP allows for the continued capacity to generate 20% more food in excess of that required by the facilities allowing the Corporation to service more patients; standardized reporting systems for cost controls and financial analysis resulting in real time information that allows for rapid management and corrective action plans; HHC with the support of Sodexo will continue to comply to the Mayor's Office food guidelines. An outside consultant was consulted to ensure that the contract with Sodexo based on a review and assessment of the cost effectiveness of the contract and future expenditures for dietary services. It was concluded that issuing a solicitation was not a risk worth taking and recommended proceeding with extending the current contract. The cost savings in the last two fiscal years of the previous contract term, FY 13 and FY 14, the Corporation accrued saving of \$15 million for each requisite period. The contract is for ten years for projected meals totaling 6.4 million to patients and 500,000 meals in the ER and outpatient areas. At the recommendation of Dr. Raju the food was sampled and the conclusion was that overall the food was bland but seasoning supplements were provided to enhance the flavor and the entrees and desserts were sufficient.

Committee Member Josephine Bolus, RN asked what was included in the proposed breakfast. Mr. Martin stated that the breakfast would include a hot meal compared to a continental breakfast.

Mrs. Bolus asked Mr. Martin to share with the group the process used for delivering the food to the patients.

Mr. Martin explained that the food is delivered in heated containers and is pre-packed and labeled before delivery to the facilities.

Mrs. Bolus asked if increasing the cost would provide better quality of food. Mr. Martin stated that it would not but that it would provide more of a selection than quality.

Mr. Page asked if the 20% excess capacity cost for setting up the plant on an ongoing basis and the number of patients are not trending upward are there any provision in the contract to address this issue.

Ms. Zurack explained that Sodexo paid for the capital and amortization costs and that Frank Cirillo, HHC's former Chief Operating Officer had tried to get the Department for the Aging (DFTA) to have their meals done by Sodexo. Sodexo paid for the risk of that 20% capacity. Perhaps HHC could explore the possibility of getting another agency to participate.

Committee Member Board Agent Designee, Patricia Yang indicated that she would follow-up with DFTA.

Mr. Rosen asked what was included in the 934 FTEs and whether it included the staff who delivers the food to the bedside.

Mr. Martin stated that it included the total staff for the delivery of the food to the patients.

Dr. Raju added that HHC would continue to monitor the patient satisfaction relative to the quality of the food but also the restrictions placed on the patients' meals by the doctor in addition to ongoing testing of the food which is a major issue that HHC has not taken lightly.

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

## **Information Items:**

### *FEMA Funding*

Ms. Marlene Zurack stated that few meeting ago the Committee was informed that HHC had reached an agreement with FEMA for \$1.722 billion to cover the cost of mitigation and restorations. At that time, the Committee had raised questions regarding the composition of those funds and the strategies HHC would deploy in monitoring the use and distribution of those funds. To address those issues, John Levy, HHC's Consultant, Base Tactical was asked to address those concerns. Mr. Levy and his colleagues at Parsons Brinckerhoff (PB) and Arcadis underwent a full year of working with FEMA on the requirements for developing proposals that would be FEMA eligible and that would harden HHC facilities, that includes Coney Island, Bellevue, Metropolitan and Coler. Mr. Levy would present to the Committee the status and highlights of that process. It is important to note that as these projects progresses the details will become more apparent and there will be changes.

Mr. Levy stated that two years ago the Committee was presented several updates on the status of the projects and FEMA. Last month an agreement was reach totaling \$1.722 billion that affects four of HHC's hospitals. Within this agreement FEMA will pay to repair the facilities on the damages incurred. In addition to providing funding to protect assets from future events and FEMA would no longer need to pay for losses in this particular event. As part of the process there were two levels of negotiations. The first addressed how much FEMA funding would be provided to HHC to protect the facilities. There was a

certain level of criteria that had to be maintained throughout the process that included life and safety of the patients, staff nurses, keeping the operating room open and needed and protect those portions of the facilities that were damaged during the storm. The \$1.7 billion has two components and each hospitals listed on the slide has a specific dollar amount. FEMA has a traditional way that allows for securing funding and that is the way the dollar amounts were determined that total the \$1.72 billion. There are also programs after the funding has been secured through the grant whereby the funding can be spent differently than the way it was initially proposed. HHC's funding proposal was made to get the largest amount of money. Also eight cases for solutions where the hospitals are better protected with different solutions and less dollars. The goal was to secure the maximum amount and protect the facilities with less funding and the excess funding can be used at any of the other HHC facilities to protect those facilities against future events regardless of the impact during Hurricane Sandy. This is a very resourceful program provided there is significant responsibility placed on the spend on the funding. Included in the \$1.7 billion grant are two amounts, \$66 million and \$170 million. Historically FEMA has had different formulas on how to pay consultants and the architectural and engineering firms. Mr. Levy stated that Base Tactical was able to carve out a very attractive benefit to HHC through the course of those negotiations so that at this point those expense will not exceed more than one third of the \$66 million and 50% of the \$170 million architectural and engineering cost.

Mrs. Bolus asked if there is a time frame for when those funds must be spent. Mr. Levy in response stated that each of the facilities has a obligated project worksheet from that point HHC has seven years following to complete the projects or request extensions. Another \$108 million was secured for other things which is increasing slightly but the primary focus is on the \$1.7 billion which is comprised of three major areas. The first baseline mitigation option starting at Coney Island would leave the facility as it is currently. As the process began in terms of securing the facility by moving things from the basement there are codes and standards that would need to be addressed that could be very costly and time consuming to achieve. To protect the facility in that manner would take at least nine years while the facility is operational at a cost of more than \$900 million. The other option included flood walls around the hospital campus that would go up each time there is a pending storm. The biggest problem with that option is that it is a single source protection in the flood wall concept. If the flood wall fail the water would go onto the campus and the facility would be back to where it is now. The best solution that would include a flood wall around the campus; a new building with new parking deck attached. The critical services would be moved to the north end of the campus. This design essentially would cost approximately \$535 million as an option to the \$900 million which provides HHC with a significant saving that can be used for other projects. Within the course of that design there is a multistory facility that allows for moving the patient services from the south to the north end of the campus. The ambulances entrance is raised coming off the side street to the second floor of the new building and below that structure would be parking. If water should get in it would wash out and allow the facility to recover and be operational in a number of hours or days.

Mr. Page asked if there are opening in the flood walls. Mr. Levy stated that there are and that there are several movable barriers that come left and right that come together and are airtight. There are a number of pumps that would pump and push the water out. The facility would be much more protected. It is important to FEMA that HHC understands that despite improvements made to its facilities in all of the major significant levels, FEMA does not want HHC to try to shelter in place because it has built its own shelter. FEMA recognized that in the event of a category 3, 4 or 5 those situations are such that those facilities would be required to evacuate.

Mr. Rosen asked if FEMA has agreed to the estimated costs. Mr. Levy stated that an agreement had been reached between HHC and FEMA on the proposed costs with the understanding that those facilities must be protected and if HHC finds other ways less than the traditional pricing FEMA would be supportive of that action. However, FEMA must agree to those options before HHC could use the funds in an alternative way.

Ms. Zurack added that the actual work is somewhat of a formula driven award. For Coney Island it is \$922 million and HHC presented the option Mr. Levy presented which totals \$535 million. In essence the current budget is \$922 million compared to current estimate of \$535 million. Therefore, HHC is in a position to cover any overruns and if this estimate holds firm throughout the completion of the project, HHC can make a request to use the balance on other projects that would harden other HHC facilities with the appropriate approval from FEMA. HHC would have that flexibility available for its use as an option.

Mr. Page added that there is some vulnerability; therefore it is important for HHC to impose the appropriate cost controls within the \$922 million given that the lead agency during the work would be aware of that option.

Ms. Zurack stated that HHC has created a governance structure given the concerns relative to the overall management of those funds as those projects move forward.

Mr. Levy stated that there is a secondary issue and overspending is a major problem; however, if that does occur and is not consistent with the FEMA process the funding would not be forthcoming from FEMA. There is an oversight Committee that has been put in place by Dr. Raju and Mr. Martin.

Dr. Raju added that the concerns raised by the Committee are valid and HHC will take the necessary steps to ensure that the appropriate oversight and controls are in place for monitoring the outcome of those projects.

Mr. Rosen asked how HHC would get reimbursed for the expenses incurred against those funds.

Mr. Levy stated that NY State has been very cooperative during the process and the cash flow to HHC will be beneficial. This is one of the largest grants FEMA has ever approved. Moving back to the presentation, at Bellevue during the storm the water flooded the basement and the emergency department wiping out the Con Edison system power and the fuel pumps in the basements which supplied fuel up to the 13th floor where the generators resided. That was the critical weakness at Bellevue and ultimately resulted in the evacuation of all of the patients. The concept shown on the slide, the basement is critical to the facility as part of the solution for Bellevue in terms of preparing for major category storm. Bellevue's proposal to FEMA included a flood wall around the facility with electronic gates that would seal the facility off. There were three proposals presented to FEMA for Bellevue of which one that included the elevation of the emergency department was rejected by FEMA given that it was not damaged by the storm. It is above the 100 year flood line. The proposal was to get it above the 500 year flood line. However, FEMA policy rejected that proposal with the possibility that at some point if the funding is available within the \$1.7 billion that project would be considered. Storm drain sanitary pumps will be installed throughout the facility. The 40 elevators would be in a water pit in the basement. The proposal is to purchase three new elevators on the exterior of the building. There will be two passenger and one freight elevator attached to the side of the building with the elevator room at the top of the building that would eliminate the threat of having the elevators flooded and would protect the facility in the event of future storms. At Metropolitan Hospital there were no significant damages due to the storm; however, FEMA did approve the funding for a protective wall around the facility and the sliding gates which would protect the facility. The nursing facility which is the long term plan FEMA can only provide solutions on land owned, controlled or an easement at Coler/Goldwater Specialty Facility. HHC only controls five feet of land around the facility and the wall could only be installed within those parameters of the hospitals. If this was done it would not be the best option for the facility given the patient population it serves. Therefore, the solution is to have HHC, NY State and NY City work with the Roosevelt Island Operating Committee (RIOCC) and come to an agreement that would allow HHC to use some of the land via an easement that would be granted. The facility would be protected by the flood walls and it would be more conducive to the patients in that environment. Some of the work involved in a FEMA claim was reflected in the seven boxes shown on the slide included in the presentation. It is important to note that the workload doubles under a FEMA claim.

Mr. Page asked if any of the funding could be used to maintain the upkeep of those flood gates and pumps that may not be used in the next ten years.

Mr. Levy stated that partially some of those funds could be used for that purpose. FEMA allows certain language relative to training and operational issues that would allow for the testing of the equipment on an annual basis so that when and if a storm should occur the equipment would be operational. The goal is to find funding so that it will work.

Mr. Page asked if there would be a guarantee that after seven or ten years and the equipment was never used; it would be operational in the event of a storm and would not deteriorate.

Mr. Levy stated that the architects are trying to define that issue.

Mr. Rosen asked how HHC will monitor those funds. Ms. Zurack stated that HHC is in the process of developing a plan and would therefore ask that HHC be allowed to report back to the Committee when that process has been developed in two months which would be at the May 2015 meeting at which time the details would be presented to the Committee. The Committee agreed to Ms. Zurack's request.

The presentation was concluded.

#### *Payor Mix Reports*

Ms. Krista Olson reported that the Payor Mix Report for the 2nd quarter of the current FY 15 showed that the improvements that were achieved in the first quarter were sustained. The overall share of Medicaid discharges increased by 2.4% and uninsured decreased by 2.5%. The Exchanges began the 2nd quarter of last year and with the implementation of the ACA there are a number of changes in the process. Across HHC there were a variety of changes; however, Elmhurst had a major improvement from 11.9% uninsured to 4.7%.

Dr. Raju noted that it was a significant improvement and asked Alina Moran, CFO, Elmhurst Hospital Center to address the change.

Ms. Moran stated that the facility has been working very closely on the issue and that there were two major changes that took place during the implementation of the ACA and a major one that affected Elmhurst involved the uninsured population in terms of emergency Medicaid which is now eligible for Medicaid up to one year. In the past a Medicaid application was done each time there was an emergency medical condition compared to now that the eligibility is for a year and the facility is recertifying the medical condition and the patient now has eligibility. The process is much easier. The second piece relates to the NYS portal which has simplified the process in that it is easier for the facility to apply its patients for Medicaid with the appropriate

identification for the patient. The facility is working very closely with MetroPlus and HealthFirst. Additionally, the facility has changed the model for operations to patient centered models that is closely monitored by a metric and beside encounters are done by the staff.

Ms. Olson finalizing the reporting stated that in the adult outpatient payor mix there was a 3.1% increase in Medicaid; 4% in commercial; a 5% decrease in the uninsured. In the pediatrics payor mix there was a slight improvement but little noted changes.

**Medical & Professional Affairs / Information Technology Committee**  
**-February 12, 2015 – As reported by Dr. Vincent Calamia**

**Chief Medical Officer Report**

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

*Care Management*

Nine hospitals and five diagnostic and treatment centers have been accepted into the New York State Medicaid Collaborative Care for Depression Program. This new reimbursement-based program—which provides care management of patients with depression in primary care—replaces the grant-based funding of this service through the Hospital-Medical Home Demonstration project, which ended in December 2014.

The participating facilities will be paid on a per member per month basis for patients being care managed by nurses or social workers in the primary care setting. As part of the Hospital-Medical Home project, staff have been trained in the collaborative care model for patients with depression and chronic disease and there has been some augmentation of RN staffing at facility level.

Average depression screening rates increased from 68% at the beginning of the project during Q2 2013, to an average of 95% during Q4 2014. Depression screening yields have more than doubled, increasing from 2.86% in April 2014 to 8.22% in December 2014.

The new reimbursement-based Medicaid Collaborative Care for Depression Program allows us to sustain our efforts to deliver collaborative care to primary care patients—while also providing an opportunity to redouble our efforts around quality of care.

*Accountable Care Organization (HHC ACO)*

ACO Quality Reporting for 2014 performance is underway, involving HHC-wide mobilization of electronic and manual performance data in partnership with facility Quality Management teams, IT, and ACO leadership. In addition, we are reviewing the materials from NYS DOH on a future Medicaid ACO for this state. This information is being considered as part of the next strategic plan for HHC's ACO.

ACO Leadership Teams from across HHC met on February 11th for their quarterly Leadership retreat to share experience and best practices. Innovative pilots from Coney Island and Gouverneur were highlighted as opportunities for shared learning.

*Laboratory Services*

**Blood**

The recently formed Blood Bank Council which includes all HHC Blood Bank Medical Directors is fully engaged and meeting monthly. Its role is to recommend on policies and review operational performance. In addition, the standardization of the use HCLL (blood bank software) at all 11 HHC Blood Banks has been completed. As part of the Blood Bank HCLL Change Control (software) process, all blood banks meet weekly via conference call and review all software configuration changes requested and agree/reject configuration changes allowing for on-going standardization and control of the blood bank software.

**General**

The Pathology Laboratory Directors Council which includes Laboratory Directors from each HHC facility is now fully engaged and meeting monthly.

**Work Standardization**

Jacobi, North Central Bronx, Queens and Elmhurst laboratories have identified subject matter expert teams specifically involved in the further configuration design of HHCs Cerner Laboratory Information System in the areas of AP (Anatomical Pathology), Microbiology and General Laboratory. The first on-site meetings were completed this week. Participation from all HHC facilities continues the creation of standardized work practices.

Four (4) Abbott Architects have been purchased to perform HIV 4th generation testing within the hospital laboratories with the goal to perform the most sensitive HIV test available while returning the results to the Provider prior to patient leaving. This is allowed standardization of equipment across the enterprise.

**NSLIJ Reference Testing**

NSLIJ and HHC laboratory management are engaged and reviewing monthly financial information to verify financial performance is as expected. NSLIJ follow-up to HHC facilities continues in a responsive manner to resolve facility specific invoice questions.

**Pandemic Flu Tabletop Exercise**

On February 11, a system wide tabletop exercise was conducted simulating an H5NI (Avian) flu pandemic in NYC. The corporate Emergency Operations Center as well as each facility command centers were activated and linked by video. Three scenarios were tested against the current facility plans, with many learning opportunities. Dr Joseph Masci served as subject matter expert for the event. Each facility is having a debrief with a view to providing any needed revisions to their facility pandemic plans; these plans will again be reviewed after this by the HHC Emergency Preparedness Council.

**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 January 1, 2015 was 465,058. Breakdown of plan enrollment by line of business is as follows:

Medicaid	409,350
Child Health Plus	11,293
Family Health Plus	77
MetroPlus Gold	3,573
Partnership in Care (HIV/SNP)	4,913
Medicare	8,593
MLTC	815
QHP	25,082
SHOP	729
FIDA	3

As we still find ourselves in the Open Enrollment Period, complete information on QHP membership is not yet available. Although the December 2014 QHP membership was 35,424 and the January enrollment figure above is 25,082 QHP members, we are concerned that we will experience further membership loss in this line of business. We estimate to have approximately 18,000 paid, effectuated members as of the date of this report. The difference (which cannot be counted as confirmed membership) consists of both active members in their grace period (who still have the option to transfer out) and members who have not yet renewed. One of the reasons for the membership drop is that there was a significant number of previously APTC members (approximately 6,000) who had not validated their status on the NYSOH website for the new enrollment period. NYSOH automatically re-enrolled them as non-APTC members which lead to MetroPlus having to bill these members full premium for the month of January. Some of these members did validate their status in the meantime, and therefore should receive APTC credit starting in February. However, absent their full understanding of what caused the full premium invoices, we cannot guarantee they will remain with MetroPlus.

On a positive note, New York State of Health released the Medicaid Managed Care enrollment figures by county and plan. In NYC, although present in only four boroughs, MetroPlus has the second highest Medicaid enrollment (a 12.5% increase from 2013), following HealthFirst.

The HARP Go-live will be delayed until July 1, 2015. Approval from CMS is expected by March 31, 2015. Passive enrollment with opt-out provisions will begin April 1, 2015, with an effective date of July 1, 2015. The HARP delay will not affect our going-live with our other lines of business. We continue to move forward with implementing the delegation of all Behavioral Health and Substance Use Disorder services to Beacon Health Strategies. Effective January 1, 2015, Beacon is fully delegated for the FIDA line of business. All other lines of business are delegated effective February 1, 2015. Beacon is still in the process of contracting for Behavioral Health and Substance Abuse services with the HHC system through HHC’s Office of Managed Care. Members in all lines of business have been sent letters of notification explaining MetroPlus’ delegation of functions to Beacon. Additionally, members who have terminating providers will receive “Transitional Care” letters which explain that the members are allowed to continue care with their current provider during the transitional period. HHC/Beacon process trainings are currently being designed and scheduled with the assistance of HHC’s Office of Behavioral Health and Managed Care Office.

MetroPlus took part in several conference calls with OMH, OASAS, SDOH & DOH-MH in regards to our request for two licenses. One license was requested for the mainstream HARP and another license as a HIV SNP HARP. We have been given Conditional Approval for the BH-MCO (Medicaid plus SSI Carve-In) and for the BH-HARP lines of business. SDOH decided, on



January 16, 2015, that none of the three HIV SNPs will be designated as HIV-SNP-HARP. HARP services will become available to HIV SNP members while remaining in the HIV SNP line of business. The State discussed two possible solutions: a two-rate tier under the HIV SNP, or expanding the rate for all HIV SNP members so as to include the needed additional funds for the HARP eligible. The State will provide more details in the next few months.

The MetroPlus 2015 Strategic Plan was reported to the committee. The Foundation of the Strategic Plan will be built in six (6) major areas:

1. Growth and Development
2. Financial Stability
3. Medical Outcomes
4. Compliance
5. Organizational Effectiveness – Technological Excellence
6. Organizational Effectiveness – People and Processes

### **Chief Information Officer Report**

Bert Robles, Senior Vice President, Information Systems provided the Committee with the e-Prescribing Initiative and Meaningful Use update on several critical initiatives that are underway: e-Prescribing (eRx) and Meaningful Use (MU) as well as the status of HHC's Epic Electronic Medical Record (EMR) Implementation Program.

#### *e-Prescribing:*

As of March 27th, the I-STOP (Internet System for Tracking Over-Prescribing) law requires physicians, nurse practitioners, physician assistants, midwives, dentists, podiatrists, and optometrists ("prescribers") in New York State to issue prescriptions electronically directly to a pharmacy, with limited exceptions. This new law requires electronic prescribing for all types of medications (controlled substances and non-controlled substances) dispensed at a pharmacy in New York.

Presently, there are 14,594 prescribers across the 21 facilities at HHC. Of these, 9,878 are attending and mid-level providers and 4,716 are interns and residents.

Since my January report to this committee we have made some important advances in our progress to meet the March 27th deadline but we also continue to face significant challenges. Today, I'd like to highlight some major areas with you.

#### *Improvements:*

e-Prescribing software functionality is live at all sites. If prescribers are registered and trained, they can begin to e-Prescribe with the exception of those prescribers at Seaview, McKinney, Carter and Coler. These facilities will require additional preparation since they do not use QuadraMed. Meetings have been scheduled with leadership so that they are aware of the implementation plan.

One-third of prescribers were trained on QuadraMed/DrFirst last month. Pharmacy applications were registered with SureScripts and are ready for activation. Training of pharmacists began this week. Elmhurst Emergency Department is using AllScripts. The contract has been signed and software is currently being tested. The activation plan is scheduled for March 11, 2015. Internal Communications/Marketing: Discussion with HHC's Internal Communications group continues and an article on e-Prescribing was published this week in the HHC Insider. eRx screen savers have also been pushed out. In addition, eRx brochures are in production and will be converted in 13 languages for patients. The eRx pilot at Kings County Hospital is ongoing and continues to expand the implementation to more prescribers. Meetings led by Roslyn Weinstein, Sr. Assistant Vice President with HHC Facility Chief Operating Officers (COO) have taken place. The COOs were made aware of the workflows, project status, implementation plans and challenges.

#### *Challenges:*

Registration of prescribers continues to be a challenge. Email addresses of prescribers are required for non-controlled and controlled substance registration with DrFirst. All notifications, including passwords, will be sent directly to prescribers via this email address. Compliance with the use of HHC sponsored e-mail addresses by medical staff has been difficult. The Email address entered in QuadraMed is also captured on the visit summaries which eventually displays on the patient portal. A meeting with Salvatore Russo, HHC Counsel and his legal team was held regarding the use of personal email for e-Prescribing registration. Resolution of this issue is still pending. Hard tokens for two factor authentication (TFA) is a requirement for controlled substance e-Prescribing. There is a \$35.00 cost per prescriber should HHC decide to provide each prescriber a hard token. With approximately 14,594 prescribers at \$35 each will result in a cost of \$507,500 which is cost prohibitive. In contrast, a soft token TFA can be downloaded to smart devices, i.e. iPhones, Blackberry and/or iPad, without cost. This is a highly recommended form of TFA; however, prescribers have legal concerns regarding the use of their personal devices. These concerns were also discussed with Mr. Russo and his team. Resolution of this issue is still pending. Education and

awareness on the adoption of the new process remains a considerable challenge. The staggering number of prescribers in the 21 facilities impacts the capacity for user training and support.

These challenges are being monitored carefully and continue to be addressed by Dr. Mabelle Allen, Roslyn Weinstein, Drs. Peter Peacock, Glenn Martin, Aaron Elliot and Maricar Barrameda. We will continue to keep you updated as to the progress of this important initiative.

*Meaningful Use (MU) Update:*

As of January 2015, out of 2115 hospitals across the United States that were eligible to attest for Meaningful Use (MU) Stage2 Year 1, 1814 or 77% have attested. To date, HHC has received additional Medicare MU funds in the amount of \$3,262,113.21 for a total payment of \$ 8,040,786.03. Medicaid attestations were submitted in January with MU funds still pending. We are expecting an additional \$8 million in 4-6 weeks. For MU Stage2 Year 2, CMS has announced that it will issue a rule in spring easing the requirements for 2015. CMS plans to reduce the reporting period to ninety (90) days instead of a full year. It also intends to shift hospitals to a calendar year reporting period to provide hospitals with more time to adopt the 2014 version for a certified Electronic Medical Record. For MU Stage 3, the Proposed Rule is still under review.

*Epic EMR Implementation Program:*

I wanted to update the Committee members as to the status of HHC's Epic EMR Program implementation. We are currently in the build phase of this implementation with a planned go-live at the Queens Health Network in the first quarter of calendar year 2016.

*Infrastructure:*

With respect to our current accomplishments in Infrastructure, we have selected an Enterprise Content Management (ECM) vendor –Hyland Onbase which will connect information from various clinical and financial systems to integrate into the EMR to create one comprehensive patient record. An initial design session was conducted in November and readiness planning for the integration of Epic and ECM is in progress. On January 12th, a joint meeting was held with the HHC Infrastructure team and Cerner/North Shore for the implementation of our laboratory joint venture. Progress continues on this front. In addition, we have completed an overall hardware inventory analysis and gaps have been identified. Procurement planning is in progress.

*Service Management:*

In the area of Service Management, the Request for Procurement (RFP) process to identify support for an Epic Service Desk is underway. At this point, responses to the RFP have been received and reviewed. A meeting with Supply Chain Management has been scheduled to verify minimum requirements and a Selection committee has also been convened to identify the successful respondent. This process remains on track for our current projected go-live date.

*Clinical Information Systems:*

To date, over 375 clinical work groups have been convened to review and validate content and work flows. Work continues with HHC's Clinical Subject Matter Experts (SMEs) to document workflow and support results routing in all patient contexts (i.e., Emergency Department, In-and-Out Patient and Home Health).

*Training:*

Since April 2014, 106 Epic EMR Program team members have earned approximately 230 Epic certifications. The HHC Training Center for Epic end user training is slated for completion in February 2015. This training facility will be housed at Metropolitan Hospital Center and will have seventeen (17) state-of-the-art technical classrooms which will be used to train staff on the various Epic applications 24 hour/7 days/week prior to go live. To date, over 85% of the clinical lesson plans associated with this training have been completed for roughly 140 unique end-user classes.

*Communications:*

With regards to the Epic EMR Program communications, the program's Sharepoint site has had over 195,849 cumulative hits since its inception in spring 2013. To date, the Communications team has produced and distributed over 30 monthly newsletters on EMR implementation, with an average of 10,000 views per issue. Seventy-five (75) weekly updates on the EMR implementation have also been published and disseminated, with an average of 8700 views per issue.

Over the next ninety (90) days, Clinical Information Systems will continue to conduct workgroup sessions with the various SMEs across HHC. The Leadership Activation Team meetings at the Queens Health Network are slated to reconvene. In the late spring, EITS is planning an "ICIS Day in the Life" sessions for facilities to participate in.

Going forward, EITS each month will either be reporting or presenting different aspects of the Epic EMR program to the Committee in preparation for our go-live in the first quarter of Calendar Year 2016.

## Information Items:

Christina Jenkins, MD Senior Assistant Vice President, Quality and Innovation presented to the Committee the Delivery System Reform Incentive Payment Program (DSRIP).

NYS received federal approval to implement a DSRIP program that will provide funding for public and safety net providers to transform the NYS health care delivery system. Accomplishments from July through December 2014 that took place were, project finalized and, aligned across the city. Completed community needs assessment and completed initial project planning. Several key collaborations with other PPSs, convened first PAC meeting on 11/18, Assessed partner capabilities through multiple surveys, submitted final partner list, completed organization and project plan application. Launched Capital Application Process and HHC board approved creation of Central Services Organization.

### *Implementation Planning: High-Level to Local*

Over 6-8 weeks, develop a high-level, standardized template for the clinical guidelines and operational workflow components of each project. Small workgroups representative of PPS and comprised of those with deep expertise will develop these templates using clinical and programmatic best practices. Our aim is to define the “must-have” elements of each project, in order to standardize as much as possible. These templates will be reviewed by the PPS Care Models Committee. Once high-level planning is well underway, launch local (hub-based) planning. During this phase, we expect to augment the “standard” templates to accommodate local variations in resources and capabilities. Identify well-respected leaders who will help teams implement projects at the local level. Our aim is a completed “manual” for each project and for each partner type – it can be used as a staff resource, to be modified over time.

### *Capital Application Process*

The NYS Capital Restructuring Fund is \$1.2 B to be distributed from NYS to PPS partners over 6 years for capital projects that will promote sustainability of DSRIP transformation. As PPS fiduciary, HHC will aggregate, prioritize and submit capital applications from all PPS partners to NYS. We expect to submit ~\$800M worth of applications.

### *PPS Executive Committee Roles, Responsibilities, and Membership*

Provide strategic leadership of DSRIP-activities. Review and approve operating plans and budgets of each hub, and forward such operating plans and budgets to HHC for approval. Review and approve proposals from the CSO for the allocation and distribution methodologies for DSRIP funds, and forward such proposals to HHC for approval. Evaluate the performance of Participants as part of the PPS based on reports prepared by the CSO. Facilitate consensus-based decision making among the committees and Hub Steering Committees. Develop concrete goals in conjunction with the CSO to ensure a transition to value-based payment models. Appoint initial members to all Committees via Nominating Committee.

### *Centralized Services Organization (CSO) Structure and Function*

HHC is lead, or fiduciary, of PPS. -- Reports to HHC and works in service to the PPS, responsible for DSRIP, implementation and for meeting obligations to enable performance. Services will include: Information technology, Performance data tracking and analysis, Partnership management, Project protocol design and evaluation, Finance functions, including budgeting and funds flow, Workforce development oversight, Healthcare management consulting services. Because of its structure, an employee of OneCity Health Services is an employee of HHC.

### *Appendix: HHC-led PPS Application Scoring*

Overview of Independent Assessor Application Scores: PPSs received the Independent Assessor score for each of the projects they committed to in their December 22nd application. The score for each project combined the total project score, the total organizational score, and any additional bonus points. The Project Approval and Oversight Panel (PAOP) has the ability to accept or change the subjective portion of each PPS' score.

Our PPS Organizational Scores: All organizational scores were subjective, except for the Workforce Strategy score. The Workforce Strategy score included four possible objective points. For all pass/fail scores, OneCity Health received a passing score.

Our PPS Project Scores: Subjective Scores: OneCity Health scored at least 94% on each project's subjectively-score sections, except for project 2.a.i, (IDS), for which it received 82% of possible subjective points. The weighted average score for these sections is 96.92. Objective Scores: OneCity Health received between 70% and 77% for each project's objectively-scored sections, with one exception, Project I I, for which we received 94%. The weighted average score for these sections is 75.72.

Independent Assessor Scoring Take-Aways: We scored very well on the organization-wide score and the project-subjective score, and received lower scores on the speed and scale scores – consistent with all other PPSs in the City and the State. We made a deliberate decision to be conservative on speed and scale, given the size and complexity of our PPS. We remain convinced that our conservative approach will help us maximize our performance. We will not know final valuation until

Project II (project for engagement of uninsured and Medicaid non-and low-utilizers) bonus points are awarded and valuation attribution is released in mid-March.

### **Strategic Planning Committee – February 10, 2015**

#### **As reported by Josephine Bolus, RN**

#### **Senior Vice President Remarks**

##### *Federal Update*

Ms. LaRay Brown provided a report on President Obama's budget request, which was unveiled in early February. The House and the Senate Budget Committees will then craft their respective Congressional Budget Resolutions. Ms. Brown highlighted key issues that were of importance to HHC that were included in the President's budget request for federal fiscal year 2016. These issues included:

- Medicare and Medicaid provider cuts totaling \$431.3 billion over ten years
- \$7.7 billion in additional funding for Medicaid
- \$11.8 billion in new funding for the Children's Health Insurance Program through 2019
- 10% reduction in Indirect Medical Education (IME) funding
- \$2.7 billion in annual funding over three years (total funding of \$8.1 billion) for community health centers

Mrs. Bolus asked for clarification concerning the Medicare and Medicaid provider cuts and the additional \$7.7 billion in Medicaid funding. Ms. Brown explained that the \$431.3 billion reduction was being proposed for Medicare and Medicaid providers over ten years; and the \$7.7 billion would be additional funding provided to state Medicaid programs. These funds are to cover additional spending that states will incur as newly eligible individuals are enrolled in Medicaid as a result of the exchanges.

Ms. Brown informed the Committee that, last week, the Federal Government approved HHC's and its co-applicant, Gotham Health, FQHC's, application for Federally Qualified Health Center Look-A-Like (FQHC-LAL) designation. She added that, going forward, HHC would have to consistently monitor proposals in the federal budget concerning FQHCs in addition to monitoring the federal and state budget impacts on hospitals and HHC. Ms. Brown cautioned that there are some good and bad proposals in the President's budget concerning FQHCs. The President is seeking to add \$2.7 billion in funding for community health centers over the next three years as part of the continuation of the Affordable Care Act (ACA). Ms. Brown explained that the ACA provision that provided \$8 billion in funding for community health centers would expire this year. The President is seeking to keep that investment going. Ms. Brown commented that the funding proposal may not live through the budget process because a lot of the funding requests are at risk. The newly enjoyed Gotham Health FQHC LAL status comes with new risks including the funding for community health centers.

Ms. Brown reported on another significant key issue in the President's budget. She reminded the Committee that there had been talks since the enactment of the Affordable Care Act (ACA) concerning the threat of reduction in New York State's Medicaid Disproportionate Hospital Share (DSH) funding and ultimately to HHC. Ms. Brown highlighted the Medicaid reductions that had already been enacted through the ACA and subsequent legislation:

	FFY 2017	FFY 2018	FFY 2019	FFY 2020-2024
Estimated New York State Medicaid DSH Cut Percentage	16%	51%	51%	37%
HHC Losses-in millions including local match	(\$180.8)	(\$508.4)	(\$576.1)	(\$421.8)/ yearly

Ms. Brown explained that an initial source of funding of the ACA was to reduce DSH funding and to use those funds to pay for the cost of newly insured individuals. The assumption is that DSH funding would be used principally to support hospitals and states that provide a significant amount of care for uninsured individuals and would also address the significant underpayment around fee-for-service Medicaid. Moreover, the assumption is that the more people that are enrolled in insurance, the less need there would be for DSH funds. Ms. Brown added that, this assumption is known not to be true, principally in geographies like New York, Florida or Texas where the ACA does not fully include immigrants, particularly undocumented immigrants.

Ms. Brown reported that, in FFY 2017, New York State's Medicaid DSH funding is expected to be reduced by 16%, which would mean a cut of over \$180 million from HHC's total Medicaid DSH fund of \$1 billion. Additionally, in FFY 2018, the state is at risk of losing a little more than half of its Medicaid dollars and the impact to HHC would be at least half of its existing \$1 billion Medicaid DSH fund. What is significant about the President's new budget request is that he has added another year onto what has been the end of these DSH cuts. Ms. Brown explained that additional years had been added in past budgets. If the President's budget were to be implemented, the DSH cuts would go from 2017 to 2025. The additional year would be another \$421.8 million in potential cuts to HHC.

Ms. Brown reported that the President's budget also included some proposed reductions in Medicare payments for hospital outpatient based (HOPD) clinic services by \$29.5 billion nationally over 10 years. Ms. Brown informed the Committee that this was the first time that this item was included in the President's budget. The impact to HHC would be \$186.8 million over ten years.

Ms. Brown reported that the President's budget request included a proposal to reduce Medicare payments to post-acute care providers (e.g., inpatient rehabilitation facilities, home health agencies, and long term care hospitals and skilled nursing facilities) by a total of \$113.56 billion, which would result from a series of changes in policy concerning how and when post-acute care payments would be paid. The estimated impact for HHC over 10 years would be a \$20 million reduction in Medicare post-acute payments.

Ms. Brown reminded the Committee of the Inpatient Rehabilitation Facility (IRF) 75% Rule. She explained that with this rule, inpatient facilities would only be reimbursed if they are addressing a particular set of diagnoses. The current law only requires 60% of rehabilitation patients to fit into one of 13 diagnostic categories. The President's budget request proposes to raise the threshold to 75%. The 13 diagnostic categories are outlined below:

1. Stroke
2. Spinal cord injury
3. Congenital deformity
4. Amputation
5. Major multiple trauma
6. Fracture of femur (hip fracture)
7. Brain injury
8. Neurological disorders including:
  - Multiple sclerosis
  - Motor neuron diseases
  - Polyneuropathy
  - Muscular dystrophy
  - Parkinson's disease
9. Burns
10. Active polyarticular rheumatoid arthritis
11. Systemic vasculitis with joint inflammation
12. Severe or advanced osteoarthritis
13. Knee or hip joint replacement

Ms. Brown stated that, because this rule had been on the table for a long time, HHC's rehabilitation facilities, both acute and long term care, have been working to redesign their services and processes to fit into the 75% rule. If this rule is implemented, the impact to HHC would be nominal because HHC has already put in place the necessary services, assessments and screenings in preparation for the implementation of this new rule.

Ms. Brown reported on two perennial issues that were not included or addressed in the President's budget request:

- 340B Drug Program

Ms. Brown stated that under current law, pharmaceutical companies that participate in Medicaid must sell outpatient drugs to DSH hospitals, federally qualified community health centers and other safety net providers. HHC and other providers have advocated for that discount to be extended to drugs provided during inpatient stays. Ms. Brown stated that the 20% discount would save HHC an estimated \$30 million each year. There is an ongoing threat to eliminate or scale back the program. In June, HRSA plans to issue wide-ranging 340B program guidance on eligible patient definitions and other issues. Ms. Brown commented that Dr. Raju's wish has always been for the Board to be kept apprised of potential risks on the horizon. She added that the HRSA plan was one such big risk.

- The Two Midnight Rule

Ms. Brown reported that, in August 2013, the Centers for Medicare and Medicaid Services had finalized the Two Midnight Rule. Under the new rule, only hospital stays spanning two midnights would be considered inpatient for Medicare payment purposes. A stay of less than two midnights would be considered outpatient. She reminded the Committee that the rule was established in response to many cases of patients receiving observation services for less than 48 hours but getting a bill for inpatient care. She added that, because of the push back, the implementation was delayed until March 31, 2015. Legislation was introduced in both houses of Congress asking that CMS create a new payment methodology for short inpatient stays. Ms. Brown added that HHC had already put in place procedures to comply with the proposed rule, which has resulted in a decrease in HHC hospitals' revenues.

## State Update

### New Leadership in State Assembly

Ms. Brown reported that, last week, the Assembly had elected a new leader for the first time in 21 years. Assembly Member Carl Heastie, who has represented the Bronx since 2000, will serve as Speaker for the remainder of the 2015-2016 Legislative Session. Mr. Heastie's nomination is not only historic because he is the first African American leader of the Assembly, but also because of the change in the long term tenure of Mr. Sheldon Silver who was the Speaker of the Assembly for more than two decades. She added that HHC looked forward to working with Mr. Heastie as well as being guided by Mr. Robert Nolan, Board Member, who will provide for HHC's introduction.

Ms. Brown announced that Governor Cuomo had released his proposed 2015-2016 Executive Budget on January 21, 2015. Legislative Budget Hearings would be scheduled during the month of February as well as the Governor's 30 day amendments to his budget. Following the Budget Hearings in March, each house will pass their own Budget Proposal. One-House Budgets are introduced by the various Legislative Conference Committees. Those proposals are the starting point for budget negotiations. First, a consensus on the revenue forecast must be established which is preceded by budget negotiations. Ms. Brown informed the Committee that the Budget must be enacted by April 1, 2015.

Ms. Brown reported that, while there were dozens of specific budget issues that would impact HHC, she would only focus on a few key issues that were included in the Governor's Budget. Ms. Brown reported that the \$62 billion Medicaid funding would be increased by 3.6% moving the state's spend on Medicaid from \$58.752 billion to \$62.046 billion. Medicaid spending remains consistent with the Medicaid Redesign Team (MRT) goal of keeping spending in line with the medical component of the Consumer Price Index or CPI and the Governor has proposed to make permanent the Global Cap on Medicaid spending. His budget also includes provisions for the State Health Commissioner's so-called "superpowers"- now called the Savings Allocation Plan – which allow the Commissioner to take action without going back to the legislature if necessary to keep Medicaid spending within the Global Cap. The Budget also extends the Global Cap Shared Savings Provision which will allow providers, including HHC, to receive a portion of any funds that remain unspent within the Global Cap. The Budget has provisions to implement the Basic Health Plan, which will be available for certain low-income, legal immigrants who cannot qualify for Medicaid due to their immigration status. This includes immigrants who are currently covered on "state-only" Medicaid. Additionally, the Governor is proposing to expand Medicaid coverage for immigrants who are newly eligible as a result of the President's recent actions on immigration reform.

Ms. Brown reported that the Governor's budget includes language HHC needs to ensure that it would receive the more than \$1 billion in outstanding Upper Payment Limit (UPL) payments, which Ms. Marlene Zurack, Senior Vice President, Finance had mentioned so many times in the past. Ms. Brown stated that there is a need for a language change in state legislation concerning how HHC should get those dollars. Ms. Brown informed the Committee that the State Department of Health (SDOH) had agreed to insert that language, which was included in the Budget.

Ms. Brown reported that, importantly, the Governor's Budget proposes to extend the current methodology for distributing Charity Care funding for three years (through December 31, 2018). The Budget proposes to continue to gradually phase-in changes to increase the proportion of the funding to hospitals that provide care to the uninsured, underinsured and Medicaid populations. HHC is still evaluating this part of the proposal.

Ms. Brown reported on the Capital Restructuring Financing Program. She stated that the Governor has proposed to add \$1.4 billion in new capital funding for healthcare providers to be split equally between upstate and Brooklyn, with \$700 million targeted to stabilize the health care delivery system in Central and East Brooklyn for a new hospital. Ms. Brown informed the Committee that HHC was concerned about the language concerning the establishment of a new hospital in Central Brooklyn because HHC believed that good public policy dictated the establishment of health care services in Central Brooklyn particularly those related to addressing the existing inequities in health care and the disparities in health status among the residents of Central Brooklyn and North Brooklyn. Building a new hospital would not be the best solution. There is also concern that the \$700 million would be allocated to a hospital that may not have the interest and/or the mission to serve all Brooklyn residents in Central and East Brooklyn including uninsured and low-income Medicaid patients. Ms. Brown added that providing \$700 million to create another hospital without addressing that issue would not address the real problem of the need for health care in Brooklyn. Ms. Brown informed the Committee that this issue would resurface in the future as HHC interacted with elected and others.

Ms. Brown reported that, along with the capital funding, the Governor's Budget included an additional \$290 million (\$580 million if a federal match is obtained) for the Vital Access Provider (VAP) Program to assist hospitals and health systems to adapt to the new DSRIP environment and to reduce avoidable hospital admissions by 25%.

Ms. Brown reported that the Governor also proposed a new Hospital Quality Pool of nearly \$100 million (including federal match) to incentivize and facilitate quality improvements in hospitals. In addition, the Budget would authorize the state and

managed care plans to use value-based payment reimbursement methodologies to advance the DSRIP goal for 90% of Medicaid managed care plan payments to providers to be made using value-based purchasing methodologies.

Ms. Brown informed the Committee that the Governor's Budget would also advance other healthcare initiatives including employing a new health insurance surcharge to pay for the state's health insurance exchange (the New York State of Health). The Budget also included Public Health and Health Planning Council recommendations related to urgent care centers, limited service clinics, office-based surgery and regulatory reforms related to the certificate of Need (CON) process and other issues.

Ms. Brown reported that although Albany was focused on the Budget, there had been some activities on legislation that were of importance to HHC. Ms. Brown reported that the Nurse Staffing Ratios bill has been reintroduced in both houses but has not been acted on yet (A.1548 – Gottfried/S.782 – Hannon). There are a variety of bills making changes related to medical malpractice that have been reintroduced but there have not yet been any further activity. In addition, Senator Lanza has reintroduced two bills that would require HHC to build or financially support hospitals on Staten Island. Ms. Brown stated that although the legislation had not yet been reintroduced in the Assembly, it was expected that Assemblyman Cusick would submit them soon (S.3322, S.3326). Ms. Brown reassured the Committee that HHC would continue to monitor these bills as well as other emerging issues that could affect HHC.

Ms. Brown shared with the Committee an emerging issue. She reported that New York State was moving from Medicaid fee-for-service to managed care for Behavioral Health Services. Ms. Brown explained that managed care premiums were insufficient and that current fee-for-service Medicaid reimbursement did not cover the costs for these services. Ms. Brown stated that HHC received only 77% of its costs for inpatient psych services; 73% of its costs for inpatient detox services; 29% of its costs for CPEP services; and 35% of its costs for outpatient mental health services. The total HHC underfunding is \$120 million.

Ms. Brown reported that HHC was not alone. All NYS hospitals' average costs far exceeded Medicaid rates: 79% of costs for psych inpatient services; 79% of costs for detox services; 34% of costs for CPEP services and 66% of costs for OP/MH services. Ms. Brown informed the HHC has been able to provide these critical services because in addition to fee-for-service Medicaid, HHC receives claims based and UPL payments. These two payments will be unavailable under managed care. The proposed managed care premiums for Behavioral Health are insufficient; and these payments have not been factored into the premium rate setting methodology. Therefore, there must be a premium fix. Ms. Brown stated that HHC would concentrate his advocacy efforts around this issue with the state.

Ms. Brown reported that there was a real effort on the part of the state to manage its Medicaid expenditures (\$62 billion of the state's budget). Ms. Brown explained that, when the Governor took office a few years ago, he had established a Global Cap as one mechanism to manage the spending trajectory of Medicaid. There are other mechanisms that the state is putting in place to manage that upward trend of health care spending. Ms. Brown commented that, if there is a Medicaid cut, HHC gets pneumonia while everybody else gets a cold. This is because HHC's payer mix relies not only on Medicaid, but also because HHC provides a vast amount of healthcare services in New York City to uninsured individuals.

Mr. Rosen, Board Member, commented that, if implemented, the DSH cuts would save the state a lot of money. Ms. Brown clarified that the state is concerned about the reduction of DSH funding. The state uses DSH dollars to fund not only HHC hospitals, but also the other voluntary hospitals. The reduction of DSH funding would create a hole for the state, which the state would have to figure out how to fill. The state's interest is to always optimize as much funding as they can from the Federal Government. Accordingly, the federal government's reduction or reinvestment of DSH funds means cuts to the state; and because of HHC's payer mix, this is a potential significant cut to HHC. Ms. Brown added that DSH cuts have been delayed to 2018. These cuts are being stacked up and getting bigger, which will create a bigger impact once implemented.

Mr. Rosen stated that the Republicans have stated that the President's budget would be dead on arrival; however, they seem to go with Continuing Resolutions. Ms. Brown commented that from the current majority's perspective, the President's proposed budget is dead on arrival. However, looking at prior years, many of the proposals that the President has included in his budget are proposals that were included in congressional budgets. Ms. Brown added that they will take all the bad cuts but may also take out the good things such as the continuation of the \$8.1 billion by cutting another \$2 billion for FQHCs, because they want to undo the Affordable Care Act (ACA). Ms. Brown noted that, unfortunately HHC's role in Washington, DC is to try to prevent bad things. HHC has rarely gotten the opportunity to support new, good things in recent years.

Dr. Raju referred back to the issue of managed care for Behavioral Health Services and stated that this change would have a double impact on HHC. He explained that HHC served a large number of mental health patients and does not have enough resources to take care of all the mental health needs of the City of New York. Even if a small portion of the cuts is implemented, HHC's ability to serve the mental needs of the City would be considerably diminished. Dr. Raju highlighted that this reduction of funds would have a devastating effect on the mental health population of New York City. The second impact is on other providers, apart from healthcare providers, who have been providing mental health services as well. Considering that HHC cannot exit the mental health market, if these providers decide to leave because of these cuts, HHC will end up serving a larger mental health population. He informed the Committee that HHC will be working very hard with the City and will count on elected leaders, community planning boards' as well as Community Advisory Boards' advocacy on this issue.

### *City Update*

Ms. Brown reported that, on February 3, 2015, Mayor de Blasio delivered his State of the City Address. The Mayor focused on greater opportunities including affordable housing, higher wages, and better benefits for New Yorkers. He also presented an initiative that will be led by the New York City Department of Health and Mental Hygiene to create six new neighborhood health clinics, or neighborhood hubs. The hub will provide services such as healthcare, human, social services, and other kind of resources that a particular neighborhood needs, which all will be housed in one building.

Ms. Brown reported that on, February 9, 2015, the Mayor released his Preliminary City Budget of \$77.7 billion, which is balanced in FY15 and FY16 and has \$750 million in reserves. Ms. Brown informed the Committee that the Mayor's Preliminary Budget also included funding for 45 new EMS tours and 149 new dispatchers. The Mayor's budget proposes to expand ACS training and prevention efforts; and would provide additional funding for homeless prevention and tenant legal services. The Mayor's budget also maintains funding provided to HHC in the November Plan for Ebola related costs and labor costs. Ms. Brown announced that New York City Council Speaker, Melissa Mark Viverito, will deliver her State of the City address on February 11, 2015. HHC is expected to provide testimony at the Council Health Committee's preliminary Budget Hearing on March 23, 2015.

Mr. Nolan asked Ms. Brown if the Mayor included funding in his budget for the neighborhood health clinics. Ms. Brown responded affirmatively.

### **Information Item**

#### *Presentation: ENDING THE AIDS EPIDEMIC*

Ms. Brown introduced Ms. Terry Hamilton, Assistant Vice President, Corporate Planning Services, and invited her to lead the presentation entitled "Ending the Epidemic of AIDS." Ms. Hamilton began the presentation by informing the Committee that Demetre Daskalakis, MD, Assistant Commissioner, New York City Department of Health and Mental Hygiene and Ms. Johanne E. Morne, Director of Planning and Community Affairs, NYS AIDS Institute would join her to present efforts on the global, state and local levels focused on ending the AIDS epidemic.

Ms. Hamilton informed the Committee that she was invited by UNAIDS to attend its Melbourne Conference, "Cities for Social Transformation on Ending AIDS 2014," the focus of which to target treatment scale-up in the cities most of affected to end AIDS. The rationale:

- Cities and urban areas especially affected by HIV (200 cities account for 35 million infected persons)
- No one left behind
- Resources follow need by leveraging public and private partnerships

Ms. Hamilton explained that focus of the UNAIDS Ending AIDS 2030 initiative. Twenty-five (25) high HIV incidence cities to lead the way by:

- Removing laws that hinder gender equality, human rights, and impose travel restrictions
- Reducing and preventing transmission - sexual, behavioral, and vertical transmission
- Eliminating stigma
- Strengthening care integration
- Closing the resource gap - more investment, engage young people and impacted communities

Ms. Hamilton shared with the Committee that vision zero efforts for 2030 have already begun with the goal of achieving: 90% of people who are living with HIV being diagnosed; 90% receiving care and having needed medications; and 90% virally suppressed so that their viral loads would be undetectable. Ms. Hamilton emphasized that vision zero meant zero new infections, zero discrimination and zero AIDS-related deaths. The overall goal is to prevent 28 million new infections and 21 million deaths by 2030 (21 million people is equivalent to three New York Cities).

Ms. Hamilton reported that New York State had already begun the process of ending the AIDS epidemic. It began several years ago by:

- Reshaping the approach to care by integrating HIV and other sexually transmitted infections (STIs)
- Focusing on developing diverse ways to end AIDS – need flexibility for a changing epidemic
- Continuing to strengthen extraordinary community engagement

Mrs. Bolus asked how it would be possible to end the epidemic in New York State with the constant flow of people coming into New York as soon as they become stigmatized in their own localities. Ms. Hamilton responded that it was the intention of the Governor and the community, after working very hard on this issue for quite some time, to really make New York a model of how it could be done. She added that inch-by-inch the community intended to make discrimination inhospitable in New York State and make that the model for the rest of the country.



Ms. Morne informed the Committee that she was honored to present in lieu of Mr. Dan O'Connell, Director of the Aids Institute, who was unable to attend the meeting. Ms. Morne stated that, in June 2014, Governor Cuomo had announced that he and others believed that they could end the AIDS epidemic in the State of New York. Among the key points that brought the Governor to that belief was the involvement, advocacy, passion of the community, and the partnerships between the government, public and private sectors. Ms. Morne added that the belief was further driven by the state's achievements in reducing HIV infections through injection drug use and through its successes with reducing mother to child transmissions.

Ms. Morne stated that ending the AIDS epidemic raised a lot of questions. There are over 30,000 diagnosed individuals who are living in New York State. Ending the epidemic does not mean ending lives but rather significantly reducing the number of additional lives from becoming affected by HIV. For those individuals who are diagnosed, the highest quality of care must be provided that is engaging and culturally competent, effective at achieving viral suppression and that ensures that individuals have access to support services that address barriers to care. Ms. Morne stated that there were a lot of reasons why many people come from other states to New York. The intention is to work with those individuals and to ensure that they can gain access to quality health care.

Ms. Morne described New York State's goals for ending the AIDS epidemic as the following:

- Reduce from 3,000 to 750 new HIV infections per year by 2020
- Decrease the number of New Yorkers living with HIV for the first time
- Reduce by 50% the rate at which persons diagnosed with HIV progress to AIDS within two years

Ms. Morne reported that there was a downward trend in the number of newly diagnosed HIV cases in New York State for the years 2002 through 2012. She highlighted that, in 2002, there were 6,058 newly diagnosed cases in New York State compared to 3,316 in 2012. Ms. Morne stated that the goal was to continue to build on that downward trend.

Ms. Morne reported that when comparing the time to AIDS diagnosis for new HIV cases that were not concurrent HIV/AIDS diagnoses for 2002 to 2011, the 2002 diagnoses were over the 40% rate compared to below 10% in 2011. Ms. Morne explained that targeted prevention efforts to engage individuals to seek and accept HIV testing contributed significantly to that decrease in 2011. Ms. Morne added that one strategy that was instrumental was the implementation of the HIV Testing Law in which it became mandatory for individuals ages 13 to 64 to be tested. Mrs. Bolus asked why the implementation of the HIV Testing Law did not apply to individuals older than 64 years old. Ms. Hamilton responded that the age range was based on the CDC's prevention recommendation. HHC's operating policy is to extend screening above the age of 64. Ms. Morne added, while the mandatory offer is set for the purpose of identifying individuals between the ages of 13 and 64, it also covered the issue of risk. Therefore, for individuals who fall outside of these parameters if risk is identified, it is important to ensure that the offer is made so that people would have access.

Ms. Morne described the cascade of HIV care in New York State through the year 2012. Ms. Morne explained that there were 154,000 estimated HIV infected persons. There are more than 132,000 persons living with or diagnosed with HIV infection leaving a gap of 22,000 who are believed to be HIV positive, but remain undiagnosed. More than half (68,000) of infected individuals are virally suppressed. Ms. Morne stressed that there is a need to do better and to reduce the 51%. While more than half is great, it leads to the issue of opportunity in all health care systems to ensure viral suppression. Dr. Daskalakis commented that when people are in care in New York City and New York State, they do great. He highlighted that 79% of cases with any care are virally suppressed. The data indicates what the drive should be, which is to test more individuals, link them to care and keep them in care. Once they are in care, the care that is provided is fantastic. Ms. Morne added that the same result is true for individuals receiving their care in the correctional facilities.

Ms. Morne stated that the purpose of the "bending the curve" presentation slide is to ensure that everyone understand that the intention and goal of the ending of the epidemic initiative is to get to a place where HIV infections are less than HIV related deaths. Ms. Morne reported that, in October 2014, the Governor had announced the creation of a NYS Ending the Epidemic Task Force, which included 64 individuals from across the city and state including Ms. Terry Hamilton of HHC. Ms. Morne stated that Task Force met from October 2014 to January 2015 to develop recommendations that would support the Governor's Three Point Plan and to develop a blueprint. One of the main goals of the taskforce is to ensure transparency. The taskforce was also charged with ensuring that there was opportunity for all community members to contribute, recognizing that regardless of whether one sits at the table, or from one's home or office, that they had a voice in the process of developing recommendations. On January 13, 2015, the NYS Ending the Epidemic Task Force completed its charge and finalized 44 committee recommendations that address HIV related prevention, care and supportive services. Committee recommendations were informed by 294 community recommendations and 17 statewide stakeholder meetings. The final Blueprint will contain 30 recommendations and 7 getting to zero recommendations.

Ms. Hamilton reported on the movement to patient-centered care then and now. Before 1980 and AIDS, we might have discussed what the provider would do for the patient. Now, HHC HIV care embodies the work of Ending AIDS. It builds on the patient as an actor on their own behalf to actively support the design and implementation of strategies to manage their health along with the healthcare team. The patient is the core of a multi-dimensional approach to healthcare using an interdisciplinary

team (internal and external to HHC). This approach strengthens the ability to notice, understand and address social determinants of health and requires a common electronic health record (HER). This HIV work addresses the:

- Landscape of HIV prevention and care
- Triple AIM in HIV care
- Ending AIDS and DSRIP

Ms. Morne reported that within HHC, the targets for ending the AIDS epidemic are the following:

1. Diagnose the undiagnosed
  - Integrated HIV screening using 4th generation technology, allowing for acute HIV diagnosis
2. Link and retain diagnosed patients in care with maximal viral load suppression
  - Part of the ongoing QI work of HIV Services including participation in NY Links
3. Access to Pre-Exposure Prophylaxis (PrEP) for high-risk negatives to decrease possible transmission
  - Will include Post Exposure Prophylaxis (PEP)

Ms. Hamilton stated, as part of their commitment to ending the AIDS epidemic, some of the Performing Provider Systems (PPS) in New York City have agreed to work Domain 4 population health HIV related projects. HHC has identified the following six projects and is working on them along with a number of PPSs.

The DSRIP Domain 4 HIV Projects are the following:

1. Integrate HIV screening – Improve linkage, transition counselors to Linkage Coordinators and work with CBOs and providers
2. PrEP - establish standard protocols
3. Peer Support - using model structure from NYLINKS special project of national significance
4. Consistent Messaging and Social Marketing - Consistent messaging to improve patient education, and social marketing with DOHMH to increase linkage and engagement in care
5. Virology FastTrack Plus – Improve patient screening for co-factors using a CDC supported EMR clinical alert/review system
6. Improve Cultural Competency – multi-layered integrated process, will include emphasis on building skills related to care for MSM and transgender populations and improving the ability of providers to effectively capture sexual history

Ms. Hamilton explained that cultural competency was particularly important because HHC had spent years focusing on that issue. She highlighted that the Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) community was one of the communities that is not yet well engaged in care. Ms. Hamilton referred to Metropolitan Hospital's LGBT clinic and stated that HHC has been working more aggressively with the Human Rights Campaign to ensure that healthcare is more accessible, more appealing and its staff more understanding of the needs of the LGBT community.

Dr. Daskalakis reported on the NYC HIV/AIDS epidemic from 1981-2012. At the very beginning from 1981 to the mid-1990, there were an increasing number of new AIDS diagnoses and increasing deaths. Diagnosed individuals were getting sick, did not live long and were passing away. However, with the advent of antiretroviral therapy, the new AIDS diagnoses dropped dramatically as did AIDS deaths. Dr. Daskalakis reported that as the deaths have dropped off, more and more people were now living successfully with HIV. He explained that this success was a result of the great work that is being done at HHC and other facilities throughout the city. One of the important surveillance changes happened around 2000. The number of HIV diagnosed continues to go down as the new AIDS diagnoses and more and more people are living successfully with HIV. NYC and New York State are bending the curve now. The new end of the epidemic bending the curve means that there is a need to make changes, leverage resources and press down on the accelerator to make this curve bend faster.

Dr. Daskalakis described the NYC continuum of care for people with HIV in New York City. There are some significant drop-offs but there are still some people not diagnosed with HIV who have the condition. The City is currently working on a new series of surveys in five boroughs to have an accurate number of currently undiagnosed individuals. Dr. Daskalakis explained that the process is that, once diagnosed, a smaller number of individuals are linked to care and even fewer are retained in care. He added that, once people get into a clinic, the people that are linked and retained in care, 93% of them are on antiretroviral therapy and 82% are actually suppressed. If testing is increased, linkage to care will be increased and if linkage counselors can push retention higher and get more and more people into the high quality care in New York City, these individuals would be on antiretroviral therapy and their HIV would be suppressed. Dr. Daskalakis stressed that, not only will they be healthy, but also the curve will continue to bend down because by not having the HIV virus in their blood, HIV acquisition will be prevented. This process leads to the implementation of the 4th generation testing. By finding these people early on, not only can they be put on medication and become less infectious, they can also make a significant change in the story, as 50% of new diagnoses probably come from that early phase. Dr. Daskalakis added that even though numerically small, the impact can be massive.

Dr. Daskalakis reported on the other half of the continuum, which included HIV negative people who are potentially at risk for HIV. Testing, pre, and post exposure prophylaxis are available along with the technology to do primary care. At the end of the day, what is being done in primary care is HIV prevention. He stated that, from his personal clinical perspective, he can no

longer distinguish between the individuals living with HIV from those who are at risk in terms of what the care delivery is since it has become identical. Dr. Daskalakis underscored that the opportunity for a primary care continuum for both people living with HIV and those potentially at risk is possible with all of the changes in health care delivery at HHC and other facilities.

Dr. Daskalakis described the New York City Department of Health and Mental Hygiene's (DOHMH's) emphasis and partnerships as described below:

#### DOHMH Emphasis

- NYC Testing Initiatives - the Bronx Knows, Brooklyn Knows, New York Knows – about 1.9 million tests
- Linked to Care - 75% of those diagnosed are linked to care
- Engagement in Care
- Viral Load Suppression
- PrEP and PEP detailing
- Care Continuum Dashboards

#### Partnerships with HHC

- HHC HIV Services Staff
- Co-chair and participate on Steering Committees for The Bronx and Brooklyn Knows
- Care Coordination
- Patient Education and Social Marketing
- Provider and Staff Education
- PrEP
- Cultural Competency

Dr. Daskalakis stated that HHC was doing a fantastic job pushing that agenda of the continuum of care into the land of viral load suppression.

Dr. Daskalakis reported on efforts targeting men who have sex with men (MSM) and cultural competency issues. He stated that MSM information bulletins were created and disseminated throughout the city including HHC facilities to teach people how to make their practices friendlier for MSM. He informed the Committee that efforts were being made to expand that circle and making sure that people get the tools they need to make a friendlier environment.

Dr. Daskalakis added that one of the more important pushes in the city is to test more individuals. He referred to the BE HIV SURE subway campaign, which he described as being very purposefully not a stigma-based campaign. He emphasized that DOHMH's goal was not to tell the individual what to do and what not to do, but to provide the tools for the individual to know that he is contextually HIV sure for himself. DOHMH believes that it can teach its patients how to take control whether by testing, pre or pro exposure prophylaxis, or through HIV treatment to remain healthy. He informed the Committee that the field services unit would go out and identify people who were exposed to recently HIV diagnosed individuals to test them. Of those individuals, roughly 11% to 17% of those individuals test positive and are linked to care. Moreover, information is given to the HIV negative individuals to help them to stay negative. Another role of the field services unit is to find those individuals who have been lost from care. Also, DOHMH's own surveillance data are used to identify them and bring them back.

Dr. Daskalakis described ending of the epidemic (EoE) efforts to retain individuals in care and to promote the importance of viral load suppression. This body of work includes social media and the undertaking of the following programs:

- Care coordination
- Non-medical case management
- Housing support
- Food and nutrition services
- Harm reduction, recovery readiness and relapse reduction
- The Positive Life Workshop
- Care status reports
- Care continuum dashboards

Dr. Daskalakis reported on DOHMH's efforts to educate people about prevention and pre-exposure prophylaxis through the use of the following outreach strategies:

- MSM city health information bulletin
- Ask about sexual behavior
- NYC condom availability program (37.5 million condoms distributed last year)  
Note: National Condom Day is Valentine Day
- Trans health guide

- PrEP and PEP
- Increasing awareness
- Detailing (360 practices; 800 providers)
- Implementation workshops

Dr. Daskalakis reported that the following actions must be undertaken in order to end the AIDS epidemic:

- Test individuals for HIV
- Provide pre-exposure prophylaxis for those who are at risk. Therefore, HIV negative is as important as HIV positive because someone who is at risk with an HIV negative test should also be connected to primary care. Negative or positive keep people engaged
- Empower health care and community partners to really make HIV testing a part of their mission. Just like getting a blood pressure, testing is now standard of care or a routine part of the visit
- Need to work with all of the resources to make sure that pre-exposure prophylaxis and care assistance does include resources for both drug access as well as supportive medical, social and behavioral services as well
- Interact with all the community-based organizations and others to really deal with the other hierarchy of needs including food access, harm reduction, mental health and substance abuse

Dr. Daskalakis concluded his presentation by stating that, ultimately, ending AIDS means linking and engaging patients in care.

Dr. Raju commented that when he graduated from medical school 40 years ago, HIV was one of the greatest challenges in medicine. However, in a short period of time, about 25 years ago, because of tremendous advances and the advocacy efforts, it would be very unusual for individuals to die from this disease as they once did. Dr. Raju emphasized that the advances made in dealing with the epidemic were due more to the commitment of educating the public than the clinicians and the research. Dr. Raju stated that he was very happy with the results until he went to Illinois and learned that diagnosed individuals living in Middle America were still being stigmatized and were still running into problems with being linked to care. Dr. Raju stressed that there is a need to figure out a national policy concerning the AIDS epidemic. It is hopeful that this advocacy will spread across the nation and that the great project of ending the AIDS epidemic will not be undermined with what happens in the other countries.

Mrs. Bolus commented that ending the epidemic agenda is time consuming. She asked how many staff members would be needed to implement the ending of the epidemic program.

Ms. Hamilton answered that ending the epidemic does require some additional resources. She informed the Committee that there had been some commitments made to the AIDS Institute in terms of expectations in its budget but the discussion still continues around what happens for direct care providers and what happens for direct prevention service providers. Ms. Hamilton admitted that it was unclear how to get these new resources including stable housing. However, she reminded the Committee that stable housing remained a vital adjunct to being able to deliver the expected level of care impact, as patients will not be able to come to care.

Ms. Hamilton concluded her presentation by introducing the HIV staff members to the Committee. She introduced Ms. Eunice Casey, Assistant Director, and Lydia Isaac, PhD, MSc, Assistant Director of Data, Grants and Quality Improvement of Corporate Planning Services. Ms. Hamilton acknowledged them for their hard work, especially for their most recent work in collaboration with HHC facilities and other PPSs on DSRIP.

Mrs. Bolus thanked the team for their presentation.

## SUBSIDIARY BOARD REPORT

**MetroPlus Health Plan, Inc. – January 29, 2015**  
**As reported by Mr. Bernard Rosen**

### **Chairperson's Remarks**

Chair Rosen welcomed everyone to the first MetroPlus Board of Directors meeting of 2015. Mr. Rosen stated that Dr. Saperstein would present the Executive Director's report and Dr. Dunn would report on Medical Management issues. Mr. Rosen stated that there would be three resolutions presented at the meeting including one to amend the MetroPlus Bylaws. Mr. Rosen asked Dr. Saperstein to present his report.

## Executive Director's Report

Total plan enrollment as of January 1, 2015 was 465,058. Breakdown of plan enrollment by line of business is as follows:

Medicaid	409,350
Child Health Plus	11,293
Family Health Plus	77
MetroPlus Gold	3,573
Partnership in Care (HIV/SNP)	4,913
Medicare	8,593
MLTC	815
QHP	25,082
SHOP	729
FIDA	3

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. [Reports attached to MetroPlus' minutes of this meeting]

As we still find ourselves in the Open Enrollment Period, complete information on QHP membership is not yet available. There is a significant number of previously APTC members (approximately 6,000) who had not validated their status on the NYSOH website for the new enrollment period. NYSOH automatically re-enrolled them as non-APTC members which lead to MetroPlus having to bill these members full premium for the month of January. Some of these members have validated their status in the meantime, and will therefore start receiving APTC credit starting in February. There is also a significant number of pending renewals as well as active members in their grace period who cannot be counted as confirmed members yet. We are concerned that we will experience membership loss in the QHP line of business.

On a positive note, New York State of Health released the Medicaid Managed Care enrollment figures by county and plan. In NYC, although present in only four boroughs, MetroPlus has the second highest Medicaid enrollment (a 12.5% increase from 2013), following HealthFirst.

MetroPlus continues the collaboration with HHC in an effort to increase membership referrals. Our Learning and Organizational Development team has been working with the Revenue Management Department in Central Office to coordinate Marketplace Assister training of the HHC HCIs. The first training session of 30 HCIs took place the first week in January. In addition, our Call Center and Marketing Department are working closely with HHC to increase the number of enrollments for self-pay patients who may qualify for our Exchange line of business.

Since I mentioned our Call Center, I would like to give this Committee an update on its activity. The Call Center faced many challenges in 2014 as membership grew due to the implementation of the Affordable Care Act. We saw continually increasing monthly call volumes which peaked at 117,753, versus a peak of 93,546 calls in 2013. A total of 1,471,727 calls have been received by our call center in 2014 as of the writing of this report: an increase of 67% over last year. Because of the increased call volumes and complexity of call types, we implemented strategies to assist us with maintaining service level metrics and increase "first call resolution" percentages. We successfully completed implementation of a new phone system (allowing for better distribution of call queues, etc.), boosted existing call tracking/eligibility systems, and enhanced training to decrease its duration without compromising call handling efficiencies or customer satisfaction. Because of the many updates/changes and daily planning, we have successfully met overall service level metrics for the past few months and we are confident we will continue this positive trend throughout 2015. In preparation for 2015 managed care regulatory changes and introduction of new lines of business (FIDA and Behavioral Health HARP) the Call Center has been appropriately staffed in order to successfully maintain call metrics, as well as increase our member outreach efforts.

The Fully-Integrated Dual Advantage Program (FIDA) went live on January 1, 2015 in Region I (NYC and Nassau) for opt-in members. Passive enrollment for this region will begin on April 1. Passive enrollment will occur over a five-month period. All enrollments (Opt-in and Passive) are through NY Medicaid Choice which will provide counseling and assistance to potential participants. All enrollments are through Medicaid Choice and plans cannot perform enrollments into FIDA. FIDA eligible individuals enrolled in a Managed Long Term Care (MLTC) plan will "convert" to their plan's FIDA product, unless they choose another plan. As of December 29, 2014, MetroPlus has received our first three members effective 1/1/15. These were already existing Medicare Advantage members who opted into our FIDA program. One of the three members disenrolled from FIDA and re-enrolled in Medicare. We will have an additional six members with a 2/1 effective date.

The HARP Go-live will be delayed until July 1, 2015. Approval from CMS is expected by March 31, 2015. Passive enrollment with opt-out provisions will begin April 1, 2015, with an effective date of July 1, 2015. The HARP delay will not affect our going-live with our other lines of business. We continue to move forward with implementing the delegation of all Behavioral Health and Substance Use Disorder services to Beacon Health Strategies. Effective January 1, 2015, Beacon is fully delegated for the

FIDA line of business. All other lines of business will follow and be fully delegated effective February 1, 2015. Beacon is still in the process of contracting for Behavioral Health and Substance Abuse services with the HHC system through HHC's Office of Managed Care. Members in all lines of business have been sent letters of notification explaining MetroPlus' delegation of functions to Beacon. Additionally, members who have terminating providers will receive "Transitional Care" letters which explain that the members are allowed to continue care with their current provider during the transitional period. HHC/Beacon process trainings are currently being designed and scheduled with the assistance of HHC's Office of Behavioral Health and Managed Care Office.

MetroPlus took part in several conference calls with OMH, OASAS, SDOH & DOH-MH in regards to our request for two licenses. One license was requested for the mainstream HARP and another license as a HIV SNP HARP. We have been given Conditional Approval for the BH-MCO (Medicaid plus SSI Carve-In) and for the BH-HARP lines of business. SDOH decided, on January 16, 2015, that none of the three HIV SNPs will be designated as HIV-SNP-HARP. HARP services will become available to HIV SNP members while remaining in the HIV SNP line of business. The State discussed two possible solutions: a two-rate tier under the HIV SNP, or expanding the rate for all HIV SNP members so as to include the needed additional funds for the HARP eligible. The State will provide more details in the next few months.

In addition, Dr. Saperstein welcomed Dr. Christian Jenkins as the newest Board member and the Chairperson of MetroPlus' Quality Assurance Committee.

### **Medical Director's Report**

#### *Update on BH Delegation and BH HARP Preparations*

MetroPlus' delegation of all Behavioral Health and Substance Use Disorder services to Beacon Health Strategies will go-live on February 1, 2015. Beacon began managing the FIDA line of business on January 1, 2015. Beacon and MetroPlus have held training sessions with all Managed Care Coordinators and have fully coordinated with Maxine Katz in Revenue Management. Clinical Orientation sessions are scheduled in all four Boroughs for all Psychiatric Directors, Assistant Directors, BH Central Office Staff and other staff delegated by the Psych Directors. All training will be completed prior to go-live.

Beacon is in the process of finalizing the contract for Behavioral Health and Substance Abuse services with the Health & Hospital's Corporation (HHC) through HHC's Office of Managed Care. We have been informed the contract is complete and rates have been agreed upon for an initial 90 day period. A contingency plan in which MetroPlus holds the paper and delegates the administrative services to Beacon has been arranged in case issues with the contract arise. Members in all lines of business have been served with letters of notification explaining MetroPlus' delegation to Beacon. Additionally, members who have terminating providers have had "Transitional Care" letters delivered.

During a conference call with OMH, OASAS, SDOH & DOH-MH, the State indicated that members in the HIV SNP who are also eligible for HARP services will remain in the HIV SNP. It is likely that an additional rate tier will be added under this product to compensate for the additional services and reporting requirements. MetroPlus is continuing ongoing meetings with two State liaisons to help achieve all HARP readiness initiatives. Readiness review seminars and in-person meetings at the OMH Field Office took place the week of January 19th. The State has revised the timeline for the SSI Carve-In and HARP line of business which will now be implemented July 1, 2015. Internally, MetroPlus continues its work on the infrastructure to make both the carve-out to Beacon and the new HARP line of business fully operational.

#### *Update on Quality Management Activities*

To achieve full compliance with final regulations IPRO must include in the 2013 Reporting Year External Quality Review (EQR) Technical Reports, an assessment of the degree to which each managed care organization has addressed the recommendations for quality improvement made by IPRO in the 2012 Reporting Year EQR Technical Report which was distributed in July 2014. MetroPlus received three recommendations:

1. Member continue to face barriers when accessing care based on child and adult access rates and CAHPS scores.
2. The plan should work to improve member satisfaction and poorly performing HEDIS/QARR measures and
3. The plan should ensure the accuracy and completeness of its provider directories as well as provider adherence to appointment standards.

MetroPlus' Response to Reporting Year 2012 EQR Recommendations are as follows:

1. The plan has taken several steps to improve member satisfaction, especially around access and availability, which is the key driver of most of our member dissatisfaction. Although we have added additional questions around HHC facility access and we conducted robust oversampling (by HHC facility) and tied a financial incentive to the HHC facilities to raise awareness and motivate change, the process has experienced some setbacks, because of this MetroPlus is in the process of re-tooling the site specific reports that go to each facility and will target different audiences for the presentations (Department Chiefs, Finance, Managed Care). We have also added Flushing Hospital and Jamaica Hospital and 300+ individual Primary Care Physicians to our panel of providers to meet the needs of our members. We began doing Appointment Availability Survey calls (Q2 2014) so that we can measure access during the day and

after hours; the results of the surveys will be fed back to the facilities and if a physician or group fails to meet the standards, their inclusion in the MetroPlus network will be discussed at the credentialing committee.

2. In the area of follow up after a behavioral health admission, MetroPlus has made significant improvements but there are still areas for improvement for the Plan. In the latest QARR results our 30 day follow up rate was 77% and the SWA was 79% and for the 7 day follow up rate was 59% and the statewide average was 65%. We are taking steps to improve this rate by working with various home health agencies and with our Case Management Department to coordinate data and collection. We are also targeting our BP 140/90 measure, where we are currently at 61%; we will continue to work with our HHC and non- HHC physicians to keep encouraging them to get their members in for timely visits and will keep taking measures to enhance our Medication adherence program.
3. MetroPlus' communications department continually works with our vendor to produce an accurate and robust provider directory; to that end, the departments are working closely to produce the files in a timely manner, so that they are able to be proof-read, and corrected if error(s) are detected. In addition, in Q2 2015 MetroPlus Health Plan will resume our Appointment Availability (calls) conducted by CareCall to monitor our provider network to ensure that our providers are accessible to our members and will educate them through our Network Management Department (as necessary) if we find providers that violate our current process.

#### *Update Medicaid Management Benefit Changes*

##### *Residential Nursing Home Benefit Carve In*

Mandatory enrollment in MMC or MLTC to begin February 1, 2015 for new residential Nursing Home (NH) Recipients in NYC. Voluntary enrollment for individuals already residing in nursing homes will begin on October 1, 2015. After the transition, residents with a break in service (i.e. hospitalization without bed hold) will be required to enroll in a managed care plan upon returning to NH. Plan selection will be limited to those contracting with the NH in which the beneficiary resides. Auto assignment will apply to this population, and will be limited to plans contracting with the NH. There is no lock in. Plans must use UAS to assess the resident's functional needs and abilities. All enrollees will have an assigned PCP. The State plans to establish metrics to evaluate use of inpatient hospitalization and emergency rooms, and falls requiring medical intervention.

##### *Telehealth Update*

Telehealth legislation signed by Governor takes effect January 1, 2016. Telehealth is the use of electronic information and communication technologies by providers to deliver health care services- including assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. The legislation requires private insurers and Medicaid to provide coverage for services delivered via telehealth, as long as such services and providers of the services are otherwise covered under the patient's contract or policy. Telehealth services would be subject to the same co-payments, coinsurance or deductibles as if the service was provided face-to-face. Telehealth providers need not maintain a physical practice location within NYS or have an established relationship with another licensed provider who maintains a physical practice location in the State

##### *Update on the Fully Integrated Duals Advantage (FIDA) Demonstration*

The Fully Integrated Duals Advantage Demonstration (FIDA) program will begin on January 1, 2015. The three-year demonstration project is a partnership between the New York State Department of Health (NYSDOH) and the federal Centers for Medicare and Medicaid Services (CMS). Through FIDA, participants can get all of their Medicaid and Medicare benefits through one managed care plan.

As of December 1, 2014, 22 plans have fully executed contracts with NYSDOH Division of Long Term Care and CMS. FIDA Program Announcement Letters were mailed to eligible individuals in Region I which consists of the Bronx, Kings, New York, Queens, Richmond, and Nassau counties. Opt-in enrollment effective date for Region I starts January 1, 2015, and passive enrollment starts April 1, 2015.

The key features of the FIDA program are:

1. An expanded package of covered items and services, which includes original Medicaid and Medicare benefits including prescription drug coverage, as well as behavioral health, home and community based waiver services and community and facility long term care services.
2. Participants will not have to pay plan premiums, copayments, or deductibles.
3. Patient-centered service planning through an interdisciplinary team (IDT) approach. FIDA members can choose family members, doctors, nurses or personal attendants to join their IDTs to help make care decisions.

4. An integrated appeals process, through which the most consumer-favorable elements of the Medicare and Medicaid grievance and appeals systems are incorporated into a consolidated, integrated grievance and appeals system for FIDA Participants.
5. Access to services provided by ICAN. The Ombudsman will be known as the Independent Consumer Advocacy Network (ICAN).

We have three members as of January 1, 2015 with additional six to join the plan as of February 1, 2015.

#### **Action Items:**

The first resolution was introduced by Dr. Dunn.

*Authorizing the Executive Director of MetroPlus Health Plan, Inc. (“MetroPlus”) to increase the spending authority for the contract with Inovalon, Inc. (“Inovalon”) dated November 1, 2012, and to allocate additional funds for the fulfillment of the contract, with the total amount not to exceed \$1,300,000 for the term which was extended until October 31, 2017.*

Dr. Dunn explained to the Board the need for the additional funds for this contract. MetroPlus will need to purchase new tools from Inovalon to run additional measures for the new Exchange product line.

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

The second resolution was introduced by Dr. Saperstein.

*Recommend that the Board of Directors of the New York City Health and Hospitals Corporation amend the Bylaws of MetroPlus Health Plan, Inc. (“MetroPlus” or “the Corporation”) to better enable MetroPlus to conduct its business.*

Dr. Saperstein gave the Board an overview of the need to revise MetroPlus’ Bylaws. The proposed changes included adding the Customer Services and Marketing Committee as a Standing Committee of the Board and adding the position of Chief Operating Officer as a Corporate Officer.

The adoption of this resolution was duly seconded and unanimously adopted by the MetroPlus Health Plan Board of Directors and will go to the HHC Board of Directors on February 26, 2015.

The last resolution was introduced by Dr. Dunn.

*Authorizing the Executive Director of MetroPlus Health Plan, Inc. (“MetroPlus”) to increase the spending authority for and extend the contract with New York County Health Services Review Organization (“NYCHSRO”), dated April 1, 2010, and to allocate additional funds for the fulfillment of the contract, with the total amount not to exceed \$5,359,000 for the term to extended until June 30, 2015.*

Dr. Dunn gave the Board a detailed overview of the need for the additional funds for NYCHSRO.

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

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



**RAMANATHAN RAJU, MD**  
**HHC PRESIDENT AND CHIEF EXECUTIVE OFFICER**  
**REPORT TO THE BOARD OF DIRECTORS**  
**FEBRUARY 26, 2015**

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

**GSI FOLLOW UP**

At our January 29th meeting, the Board asked for more information regarding the proposed contract to build a web-based system for Health Home and DSRIP patients care coordination. At that time, the Board asked who will be paid the funding earmarked for connectivity.

The answer is: up to \$14 million will be paid to GSI Health Inc. for the completion of this work.

The Board also requested that I review and report back on GSI's capability to perform the contract. The leadership team and I have performed due diligence and have concluded that GSI possesses the financial, technical and professional capacity to execute our objectives.

We also note that the contract terms will include software escrow measures and risk mitigation strategies designed to protect this substantial investment in our future in the unlikely event that GSI ceases operations for any reason. Based on these findings, we recommend proceeding under the resolution as written and passed last month.

**POSITIVE FITCH HHC BOND RATING**

Last week Fitch, the national bond rating service, acknowledged our better fiscal performance over the past year by affirming an A+ rating on bonds issued by the Corporation. Fitch highlighted the fact that our operating margin is much improved over FY 2013, from minus 9.2 to minus 1.2. The Fitch report also noted that HHC's patient service revenue grew by 10%, and that revenue at MetroPlus grew by 6% while costs were contained at an increase of just 2%. Restoring fiscal stability to HHC is, as we are all aware, our top priority. And although we have a long way to go, last week's statement from Fitch is encouraging.

**DSRIP UPDATE**

As a group of partners working closely together to pursue a common goal, our Performing Provider System (PPS) has made great progress over the past several months. Its new name -- OneCity Health -- is one that reflects this shared commitment, to improve the health of all New Yorkers. We are in the process of developing both a logo and website for OneCity Health, and plan to share these shortly.

A PAC (Project Advisory Committee) meeting was held at Woodhull on February 4. More than 100 partners joined us for discussion.

On February 4, state released DSRIP scores for all PPSs across the state. Scores are based on the weighted sum of three components. Our scores are:

- Organization-Wide score – 97.7%
- the Project Strategies score – 96.9%
- the Speed and Scale score – 75.7%

We are very pleased with both our Organization-Wide and our Project Strategies scores. While our Speed and Scale score is lower, it reflects our realistic approach to the projects with due deference to the size and complexity of our work.

Overall, our scores are consistent with all other PPSs across NYC, and we remain convinced that our conservative approach will serve us well in maximizing our performance and helping to ensure that we meet the goals we have committed to achieving.

You will also recall that the state has allocated \$1.2 billion over the next six years for a Capital Restructuring Fund designed to promote sustainability of DSRIP transformation.

On Feb. 20th The OneCity Health submitted \$760 million dollars in capital requests to the state.

### **DIALYSIS PROVIDER UPDATE**

On February 12th the New York State Public Health and Health Planning Council voted against the pending Certificate of Need application of Big Apple dialysis service and decided to reconsider it in a future meeting.

In preparation for that meeting, the Council has asked the Department of Health to provide further information and analysis.

We now will await the State's further deliberations. We want to reiterate that access and quality are our primary goals.

### **FEDERAL UPDATE**

On February 2nd, President Obama released his recommended budget for federal fiscal year 2016. The proposals in the President's budget that are of most significance to HHC are:

- Medicare and Medicaid provider cuts totaling \$430 billion over the next ten years.
- Including reductions in Medicare payments for hospital based outpatient services of \$29.5 billion over 10 years. The impact on HHC would be an estimated \$186 million of reduced payments over 10 years.
- Reductions in Medicare post-acute care provider services by \$113.6 billion over 10 years. The estimated impact for HHC over 10 years is \$20 million.
- \$7.7 billion in additional Medicaid funding to States.
- \$11.8 billion in new funding for the Children's Health Insurance Program until 2019.
- 10% reduction in Indirect Medical Education funding for 10 years. The impact to HHC would be a \$10 million annual reduction.

- \$2.7 billion annual increase over three years for Community Health Centers.

The President's FFY 2016 budget also proposes to add another year, through 2025, of the Medicaid Disproportionate Share Hospital funding cuts that were included in the Affordable Care Act. The impact of this proposal could reduce New York State's Medicaid DSH funds by an estimated \$421 million for that year.

Also of concern are two pending regulatory developments that HHC's Intergovernmental team continues to monitor closely:

- The Health Resource Services Administration (HRSA) may promulgate wide-ranging new regulations concerning the 340B pharmaceutical discount program. Changes to current rules could negatively impact the benefit HHC derives from its participation in that program.
- Enforcement by the Centers for Medicaid and Medicare Services (CMS) of the Two-Midnight Rule in which only stays of Medicare patients spanning two midnights will be reimbursable.

### **STATE UPDATE**

The State Budget process is well underway. The Senate and Assembly will complete their Joint Budget Hearings tomorrow. In the next two weeks they will each release their own Budget Resolutions and begin the Conference Committee process to reach agreement on a final budget, which must be enacted by April 1st.

I will travel to Albany next week to meet with legislators in an effort to ensure that the Corporation's three key priorities are addressed in the final budget, including:

1. Adoption of Budget language modifying the way the State distributes our Upper Payment Limit funding.
2. Extending the current methodology for distributing Charity Care funding for three years in a way that protects us when federal Disproportionate Share Hospital funding cuts are implemented.
3. Behavioral Health Services Rates as New York transitions from Medicaid Fee-For-Service to managed care. The state's proposed premiums are insufficient because they do not reflect our costs of providing these services.

### **HHC CAMPAIGN ENCOURAGES LIFE-SAVING COLON CANCER SCREENING**

I'd like to take this opportunity to remind the Board that March is National Colorectal Cancer Awareness Month. Our system is a critical partner in New York City's efforts to control colon cancer. We are continuing our annual tradition of actively encouraging our staff, patients and all New Yorkers over 50 to get a potentially life-saving colon cancer screening.

These efforts have been a major force in closing the gap in racial and ethnic colon cancer screening disparities among Blacks, Whites, Hispanics and Asians.

### **HHC WINS 2015 HEALTHCARE SUPPLY CHAIN ACHIEVEMENT AWARD**

I'm happy to report to the Board that for the second year in a row, the corporation is the recipient of the annual Healthcare Supply Chain Achievement Award from ECRI Institute an independent, nonprofit organization that researches the best approaches to improving patient care. The Institute recognizes initiatives that include spend management and analytics for medical devices. It also seeks to highlight clinically sound and financially savvy approaches to technology decision making. The winning organizations were chosen from nearly 3,000 hospitals and health systems.

This award, for the second year in a row, recognizes our effectiveness in improving healthcare quality and reducing costs by adopting supply chain best practices. Congratulations to all staff responsible for achieving this outstanding award, particularly to Paul Albertson, Senior Assistant Vice President and Jun Amora, Director of Strategy, who have lead this effort under the direction of Executive Vice President Antonio Martin

### **ROBERT NOLAN AWARD**

Also concerning awards, I'm pleased to recognize that our fellow HHC Board Member, Robert F. Nolan, has been named a recipient of the United Hospital Fund's 2015 Distinguished Trustee Award for dedication and leadership in governing not-for-profit hospitals.

An awards luncheon honoring Bob and the other recipients will be held on Monday, May 11, from noon to 2 pm. Our congratulations to Bob for this prestigious and well-earned recognition.

### **APPOINTMENT OF ANTHONY RAJKUMAR AS EXECUTIVE DIRECTOR OF HHC METROPOLITAN HOSPITAL CENTER**

We were very pleased to announce that Anthony Rajkumar has been appointed Executive Director of HHC Metropolitan Hospital Center (MHC).

Mr. Rajkumar is not new to our organization having served in various leadership roles in Queens and Central Brooklyn networks. He brings a wealth of experience to Metropolitan, with nearly 30 years of leadership experience.

### **FEATURED HHC PROGRAM OF THE MONTH FAMILY COURT MENTAL HEALTH SERVICES**

As you know, each month at the Board meeting we highlight one of our programs that exemplify an essential service we provide to New York City which is more than quality health care -- affordable health care. This month I call your attention to our Family Court Mental Health Services program.

At Family Court Mental Health Services clinics across the city, psychologists, psychiatrists and staff conduct mental health evaluations for individuals referred by Family Courts. These clinicians offer professional advice to judges make life-changing rulings---  
--- whether children should be separated from their parents, or  
--- whether a juvenile delinquent should be returned home or placed in a residential facility.

I've said many times that cultural competence and sensitivity are hallmarks of The Health and Hospital Corporation. We understand them better than anyone else. We "are" the communities we serve. Our understanding of diverse communities across the city makes us superbly well-qualified to help the courts "get it right" when deciding terribly difficult cases.

I wish to share with you a case -- a case these clinicians assisted with recently in the Bronx.

This team was asked to evaluate a Congolese-American woman's fitness to parent to her young daughter.

The woman has endured great emotional trauma. She was a victim of torture prior to her coming to the USA. Her story is complicated further by an acculturation growing up in the Congo, involving a belief in demons. Unfortunately, secretive practices of faith-based child abuse are not uncommon in that part of the world, where children who are disabled, wet the bed or, suffer nightmares, are sometimes accused of being possessed by demons. Sometimes these children are forced to endure painful rituals, starvation or beatings.

While such practices may be a day-to-day occurrence in those parts of the world -- obviously they are abhorrent to our thinking. Many would consider holding these superstitions as evidence that this mother was unfit to parent.

In this case however, our clinician's knowledge of Congolese culture helped the court to look empathetically at the negatives and to recognize the mother's strengths. She was evaluated as not posing a threat of harm to her child.

It turned out that she is educated, resourceful and has demonstrated an ability to hold on to a job. Our clinician was able to come to know this woman with an open mind, and to judge her past in Congo not by our standards but by the reality of life in Congo -- only to conclude that it was better for the family -- the child and the mother -- to continue supervised visits.

This degree of cultural sensitivity and expertise shows the value that so many of our programs add to the City. I am delighted to bring your attention to this program, and hope you'll share my enthusiasm in congratulating its staff for work well done.

Let's have a round of applause for Dr. Marcia Werchol, Assistant Vice President for Family Court Mental Health Services and Michael Duncanson, Program Director.

**FEATURED HHC INDIVIDUAL;  
JOHN JENNINGS, ASSISTANT DIRECTOR, FINANCE**

Over the past year I have highlighted many employees doing outstanding clinical work at our facilities, in the field and abroad. However, a person doesn't need to be doing dramatic work to be a hero.

They might be a hero working quietly in an office, performing a job without fanfare that is essential to the system's operations and future well-being. John Jennings, Assistant Director of Revenue Management and Operations is such a man. I am glad to honor him today.

I've said many times in the past year that achieving financial stability is one of our most pressing goals. Without this, we will be unable to continue fulfilling our mission to provide care for all who need it in New York City.

John Jennings is on the frontline of helping us achieve our financial objectives. He helps this organization succeed in the most fundamental way, by remaining financially viable.

His work may not seem dramatic, but John ensures that we receive every cent of every Meaningful Use incentive dollar that we've earned by deploying new technology across our system.

For many of us, this work might not make the pulse race---but viewed in terms of ensuring our survival, it's no less heroic. And it's what John Jennings does.

John has dedicated his professional life to the corporation. He started here after graduating from SUNY Brockport in 1978. He's a native Long Islander, with deep roots, family and friends there.

John does a tremendous job making sure that we meet all of the verification, enrollment and authorization requirements necessary to keep the pipeline of federal incentive dollars flowing. Through his diligence, and that of his colleagues, we have earned \$116 million in Meaningful Use payments to date.

John's intelligence, specialized expertise, and commitment are great assets to the corporation. We've been lucky to have him on the job for the past 36 years. I am hoping that after today's recognition perhaps we can persuade him to stay another 36. Join me in giving him a greatly deserved round of applause.

## **HHC IN THE MEDIA HIGHLIGHTS**

### **Broadcast**

Elmhurst Hospital Art Exhibit Highlights Survivors of Torture, NY1 News, Elmhurst, Dr. Braden Hexom, Associate Medical Director, Libertas Center for Human Rights Elizabeth McInnes, Case Manager, Libertas Center for Human Rights

Wile E. Coyote inspires new way to diagnose concussions, CBS Evening News, Bellevue: Dr. Uzma Samadandi

Ebola Doctor Craig Spencer Speaks Out, WNBC, Bellevue: Dr. Laura Evans

City Hospitals Privatization Efforts Rebuffed, WNYC, HHC, Elmhurst, Metropolitan, Lincoln, Harlem, Kings

Firefighters Fight Smoldering Warehouse Fire for Second Day, WNBC, HHC

In Foster Care, Treating the Trigger, WNYC, Bellevue: Dr. Jennifer Havens, Director of Child and Adolescent Psychiatry; Isaiah Pickens, PhD; Ashley Bujalski, START clinician

Sexual Assault Treatment Program Needs Volunteers, News 12 Bronx, NCBH: Elaine C. Garbaty, LCSW-R, SATP Coordinator; Debbie Hayashi, LCSW, SATP Advocate Coordinator; Jacobi, Lincoln

BronxTalk, Bronxnet.org, Jacobi, Dr. Noe Romo, Medical Director, Stand Up to Violence (SUV); Edwin Mendoza, Outreach Worker, SUV

NYC Doctor Who Contracted Ebola to Speak at Wayne State University, WNBC, Bellevue

Bilingual Health Insurance Enrollment Counselors, NY1 News, HHC, Elmhurst, MetroPlus, Gabriela Mayorga, Community Relations Coordinator

## **Print**

New York health expert gives tips on mastering Obamacare enrollment, New York Daily News, MetroPlus, Seth Diamond, COO

Metropolitan Hospital Center Names Anthony Rajkumar Executive Director, Capital New York, Dr. Ram Raju

HHC Metropolitan Hospital Center Names Anthony Rajkumar Executive Director, Becker's Hospital Review, Dr. Ram Raju

HHC Bond Rating, Crain's Health Pulse, HHC, MetroPlus

Fitch Affirms New York City Health and Hospitals Corp. Revs at 'A+'; Outlook Stable, Reuters, HHC, MetroPlus, Bellevue, Coney Island

In Treating Ebola, Even Using a Stethoscope Becomes a Challenge, The New York Times, Bellevue: Dr. Laura Evans

State to receive \$32 million from Feds for Ebola Spending, Capital New York, Bellevue

HHC Extends Contract, Reports Payer Mix, Crain's Health Pulse, HHC President Dr. Ram Raju; Kings County

Look-Alikes OK'd, Crain's Health Pulse, HHC, Gotham Health

HHC Sues HHS for \$15 Million, Crain's Health Pulse

Shoddy HHS Calculation Cost NYC Hospitals \$15M, Suit Says, Law360

State does not approve Big Apple Dialysis application, Capital New York, Kings, Lincoln, Metropolitan, Harlem

PHHPC Defers Decision on Big Apple, Crain's Health Pulse, Kings, Lincoln, Metropolitan, Harlem

Unions gear up for another round with Big Apply Dialysis, Capital New York, HHC: Dr. Ram Raju, President

Docs' Council: No Big Apple, Crain's Health Pulse, HCC, Dr. Ram Raju, President

James Blasts BdB Over Big Apple, Capital Health Pulse, HHC, Kings, Lincoln, Metropolitan, Harlem

Big Apple Dialysis back on agenda, angering union, Capital New York, HHC, Elmhurst, Kings County, Lincoln, Metropolitan, Harlem

Quality Questioned in HHC Dialysis Sale, Crain's Health Pulse, HHC, Dr. Ram Raju

Massive fire engulfs warehouse in Brooklyn, New York Post, HHC.

Fire rips through Brooklyn warehouse Saturday, burning city and state records, Daily News, HHC

Fire at a Brooklyn Warehouse Puts Private Lives on Display, The New York Times, HHC

Hospital Archives Burn in Brooklyn Warehouse, The Wall Street Journal, HHC

In Williamsburg Warehouse Fire, Lingering Risks of New York's Analog Age, The New York Times, HHC

Damage to Records in Brooklyn Warehouse Fire Is Less Than Feared, Officials Say, The New York Times, HHC

Brooklyn Fire a Security Reminder, Crain's Health Pulse, Harlem

Q&A with Ramanathan Raju on Health and Hospitals, City & State, HHC, MetroPlus

Q&A with Corey Johnson on Health and Hospitals, City & State, HHC, MetroPlus

Confusion abounds at DSRIP oversight panel, Crain's Health Pulse, HHC

E.R. re-admissions for asthma and mental illness remain high, Capital New York, HHC

Winter Storm Juno: How hospitals prepared-and kept patients safe, The Advisory Board Company, Dr. Ross Wilson, HHC Chief Medical Officer



Five Tips To Improve Heart Health In Harlem Wellness, Harlem World, HHC, Bellevue: Norma Keller, MD, Chief of Cardiology

Heart Health in Women: Take Control and Make a Difference, The Bronx Free Press, Dr. Lekshmi Dharmarajan, Lincoln

ECRI Announces 2015 Healthcare Supply Chain Achievement Award Winners, Healthcare Matters, HHC

Big healthcare breaches affected millions before Anthem's hack, Modern Healthcare, HHC

Thyroid Disease: What you should Know, OpEd, The Bronx Free Press, Lincoln: Dr. Tasneem Zahra, MD, Chief of Endocrinology

Councilmember Ritchie Torres Participates In North Central Bronx Hospital's Reach out and Read Event, The Bronx Chronicles, NCBH

Standing O is at it again!, Brooklyn Daily, Coney Island: Dr. Jeffrey Goldberg, Chairman of Psychiatry

## **RESOLUTION**

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a ten-year extension to the contract (the "Contract") with a joint venture known as the Consortium, consisting of Sodexo HealthCare Services, US Foods, Inc. (formerly known as US Foodservice), and GNYHA Ventures, Inc. The purpose of this extension is for the Consortium to continue to manage the Corporation's food service operations and dietary workforce and provide patient and resident meals at the Corporation's acute care and long-term care facilities. The Contract will run coterminous with an existing 25-year lease agreement of the Cook Chill production plant located on the Kings County Hospital Center campus. The plant shall continue to produce the Corporation's patient and resident food needs. The Contract extension shall be for an amount not to exceed \$361,105,676.

**WHEREAS**, the Corporation and the Consortium entered into the Original Agreement in 2005, as amended by a First Amendment executed in January 2006, a Second Amendment executed in April 2008, a Third Amendment executed in February 2009, a Fourth Amendment executed in July 2009, a Fifth Amendment executed in August 2009, a Sixth Amendment executed in January 2014 (together, the "Contract"), whereby each Consortium Member provides certain dietary services to the Corporation as set forth in the Contract; and

**WHEREAS**, the Consortium has performed, in the last 10 years, all services related to the Corporation's dietary operation including reasonably acceptable patient satisfaction scores that have been sustained over the 10 years, met all contractual and regulatory requirements, and saved the Corporation an aggregate of \$57 million during the first ten years of the Contract; and

**WHEREAS**, the Contract's initial 10 year term has expired and the Corporation wishes to exercise two of its three five-year renewal options to extend the Contract for an additional 10 years, with savings to the Corporation projected to exceed \$14 million per year; and

**WHEREAS**, as part of this extension, the Consortium will invest up to an additional \$8 million in equipment and capital improvements to the Corporation's dietary facilities and Cook Chill Plant with the Consortium retaining responsibility for all amortization payments on the first \$1.5 million, and the Corporation responsible for amortization payments in excess of the \$1.5 million, up to an additional \$6.5 million all at no interest cost; and

**WHEREAS**, the Chief Operating Officer shall be responsible for monitoring and enforcing the Contract as extended.

### **NOW, THEREFORE, BE IT**

**RESOLVED**, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to negotiate and execute a ten-year extension to the contract with a joint venture known as the Consortium, consisting of Sodexo HealthCare Services, US Foods, Inc. (formerly known as US Foodservice), and GNYHA Ventures, Inc. The purpose of this extension is for the Consortium to continue to manage the Corporation's food service operations and dietary workforce and provide patient and resident meals at the Corporation's acute care and long-term care facilities. The Contract will run coterminous with an existing 25-year lease agreement of the Cook Chill production plant located on the Kings County Hospital Center campus. The plant shall continue to produce the Corporation's patient and resident food needs. The Contract extension shall be for an amount not to exceed \$361,105,676.

## RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a three and one-half year sub-sub lease agreement with the Healthcare Finance Group LLC (the "Sub-Tenant") for approximately 16,880 square feet of space at 199 Water Street, Borough of Manhattan, to house Delivery System Reform Incentive Payment Program ("DSRIP") staff at an initial rent of \$460,000 per year or approximately \$27.25 per square foot to increase at a rate of 2.5% per year with the Corporation responsible for the payment of sub-metered electricity for a total commitment over the lease term exclusive of electricity of not more than \$1,173,144.

**WHEREAS**, the Corporation's DSRIP application states that the Corporation will pursue eleven healthcare reform projects within a single Performing Provider System consisting of approximately 150 health care providers and other entities (the "PPS"); and

**WHEREAS**, substantial work is required over the next several years to structure the PPS and to develop and implement the eleven healthcare reform projects;

**WHEREAS**, to perform the needed work, the Corporation is hiring additional staff and engaging consultants; and

**WHEREAS**, office space will be required to house the work force being assembled to perform the DSRIP work described; and

**WHEREAS**, the rental will be funded through DSRIP planning grant and performance payments; and

**WHEREAS**, after considering other commercial locations as well as existing Corporation space, the 199 Water Street location was deemed most suitable for the program's needs.

**NOW, THEREFORE, be it**

**RESOLVED**, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a three and one-half year sub-sub lease agreement with the Healthcare Finance Group LLC for approximately 16,880 square feet of space at 199 Water Street, Borough of Manhattan, to house Delivery System Reform Incentive Payment Program staff at an initial rent of \$460,000 per year or approximately \$27.25 per square foot to increase at a rate of 2.5% per year with the Corporation responsible for the payment of sub-metered electricity for a total commitment over the lease term exclusive of electricity of not more than \$1,173,144.

## RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five-year revocable license agreement with Ronald McDonald House of New York, Inc. (the "Licensee") for its use and occupancy of approximately 1,100 square feet of space on the fifth floor of the D Building at Kings County Hospital Center ("KCHC") for the construction and operation of a Ronald McDonald Family Room for use by families of pediatric patients, with the occupancy fee waived and with the President having the authority to extend the license to include space at other facilities of the Corporation on a similar basis provided such extensions are reported to the Board.

**WHEREAS**, the Licensee has operated Ronald McDonald House New York since 1978 providing a temporary home-away-from-home for pediatric cancer patients and their families; and

**WHEREAS**, among the Licensee's programs is the Hospital Outreach Program including the construction of Ronald McDonald Family Rooms for families of pediatric inpatients at various hospitals in New York City; and

**WHEREAS**, the Licensee is generously willing to contribute the full cost of the construction of a Ronald McDonald Family Room at KCHC; and

**WHEREAS**, the KCHC management, with the Licensee, has identified suitable space on the 5th floor of the D Building for the Licensee to construct a Family Room; and

**WHEREAS**, the Licensee hopes to construct Ronald McDonald Family Rooms at each of the Corporation's acute care hospitals provided that suitable space can be found that is acceptable to both the Licensee and the administration of each hospital; and

**WHEREAS**, the President shall report to the Capital Committee each time he exercises his authority to extend the license to an additional facility of the Corporation.

**NOW, THEREFORE, be it**

**RESOLVED**, that the President of the New York City Health and Hospitals Corporation be and is hereby authorized to execute a five-year revocable license agreement with Ronald McDonald House of New York, Inc. for its use and occupancy of approximately 1,100 square feet of space on the fifth floor of the D Building at Kings County Hospital Center for the construction and operation of a Ronald McDonald Family Room for use by the families of pediatric patients, with the occupancy fee waived and with the President having the authority to extend the license to include space at other facilities of the Corporation on a similar basis provided such extensions are reported to the Board.

## RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year license agreement with the Staten Island Ballet Theater, Inc. (the "Licensee") for its continued use and occupancy of 5,000 square feet of space in the Laboratory Building to house administrative functions, dance instruction and hold performances at the Sea View Hospital Rehabilitation Center and Home (the "Facility") with the occupancy fee waived.

**WHEREAS**, in May 2010, the Board of Directors authorized the President to enter into a license agreement with the Licensee; and

**WHEREAS**, the Licensee, a 501(c)(3) cultural-education organization, provides dance performances for the Facility's patients and free tickets to performances; and

**WHEREAS**, the Facility continues to have space available in the Laboratory Building to accommodate the Licensee's program requirements.

**NOW, THEREFORE, be it**

**RESOLVED**, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and is hereby authorized to execute a revocable license agreement with the Staten Island Ballet Theater, Inc. (the "Licensee") for its continued use and occupancy of 5,000 square feet of space in the Laboratory Building to house administrative functions, dance instruction and hold performances at the Sea View Hospital Rehabilitation Center and Home (the "Facility") with the occupancy fee waived.

## RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to execute a five year revocable license agreement with the United States Department of Justice (the "Licensee") for its continued use and occupancy of space to house communications equipment at the Sea View Hospital Rehabilitation Center and Home (the "Facility") at an occupancy fee of approximately \$9,203 per year to be escalated by 3% per year.

**WHEREAS**, in July 2010, the Board of Directors authorized the President to enter into a five year license agreement with the Licensee to continue to house communications equipment at Sea View Hospital Rehabilitation Center and Home; and

**WHEREAS**, the Licensee has operated communications equipment on the Facility's campus since 1992; and

**WHEREAS**, the Facility continues to have space on the roof and in the elevator equipment room on the 6<sup>th</sup> floor of the Robitzek Building to accommodate the Licensee's communications equipment.

**NOW, THEREFORE, be it**

**RESOLVED**, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and is hereby authorized to execute a five year revocable license agreement with the United States Department of Justice (the "Licensee") for its continued use and occupancy of space to house communications equipment at the Sea View Hospital Rehabilitation Center and Home (the "Facility") at an occupancy fee of approximately \$9,203 per year to be escalated by 3% per year.

## RESOLUTION

Approved: February 26, 2015

*Approving amendment the Bylaws of MetroPlus Health Plan, Inc. ("MetroPlus" or "the Corporation") to better enable MetroPlus to conduct its business*

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

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

**WHEREAS**, the Board of Directors of the HHC is empowered to oversee the business operations of the Plan; and

**WHEREAS**, the Board of Directors of MetroPlus has approved a resolution recommending that the Board of Directors of HHC amend the Bylaws of MetroPlus to better enable MetroPlus to conduct its business;

**NOW THEREFORE**, be it

**RESOLVED** that modifications shall be made to the text of the Bylaws of MetroPlus amending Section 2 of Article VII to read as follows:

"Section 2. Standing Committees. The following committees shall be designated as standing committees: Executive Committee, Finance Committee, Quality Assurance Committee, Audit & Compliance Committee, Customer Services and Marketing Committee"

**AND BE IT FURTHER RESOLVED** that modification shall be made to the text of the By-Laws of MetroPlus by adding the following to Article VII as Section 7:

"Section 7. Customer Services and Marketing Committee. The Customer Services and Marketing Committee shall consist of members designated by the Board of Directors. The duties and responsibilities of the Customer Services and Marketing Committee shall be to act on behalf of the Board of Directors for the purposes of serving as the liaison between the members and MetroPlus."

**AND BE IT FURTHER RESOLVED** that modifications shall be made to the text of the Bylaws of MetroPlus amending Section 1 of Article VIII to read as follows:

"Section 1 Titles. The officers of the Corporation shall be the Executive Director (and Chief Executive Officer), the Chief Financial Officer, the Chief Medical Officer, the Chief Operating Officer, and a Secretary."

**AND BE IT FURTHER RESOLVED** that Subsection (B) of Section 4 of Article VIII of the Bylaws of MetroPlus is amended to read as follows:

"(B) Corporate Management. The Executive Director may appoint a Chief Financial Officer, a Chief Operating Officer and a Medical Director. These individuals shall have such powers and duties as shall be prescribed by the Executive Director subject to approval by the Board of Directors."



# HHC Accountable Care Organization

Building Toward Better Health, Better Care, and Higher Value

HHC Board Meeting  
March 26<sup>th</sup>, 2015

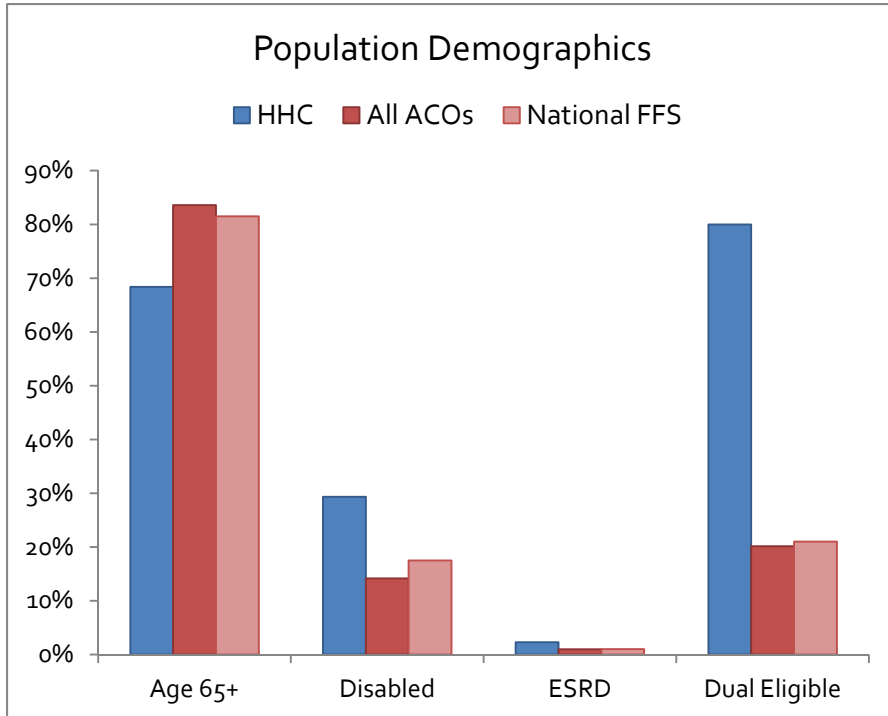
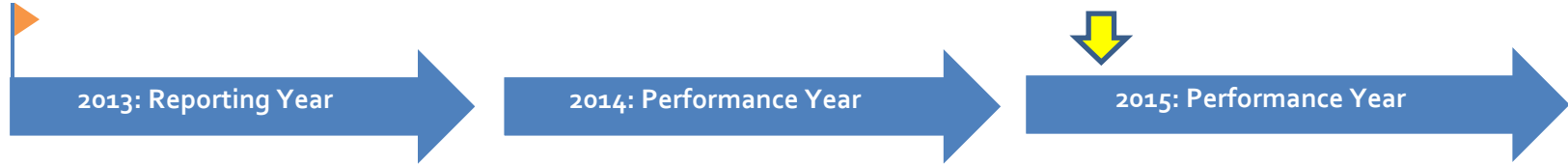


[www.nyc.gov/hhc](http://www.nyc.gov/hhc)



# HHC Accountable Care Organization

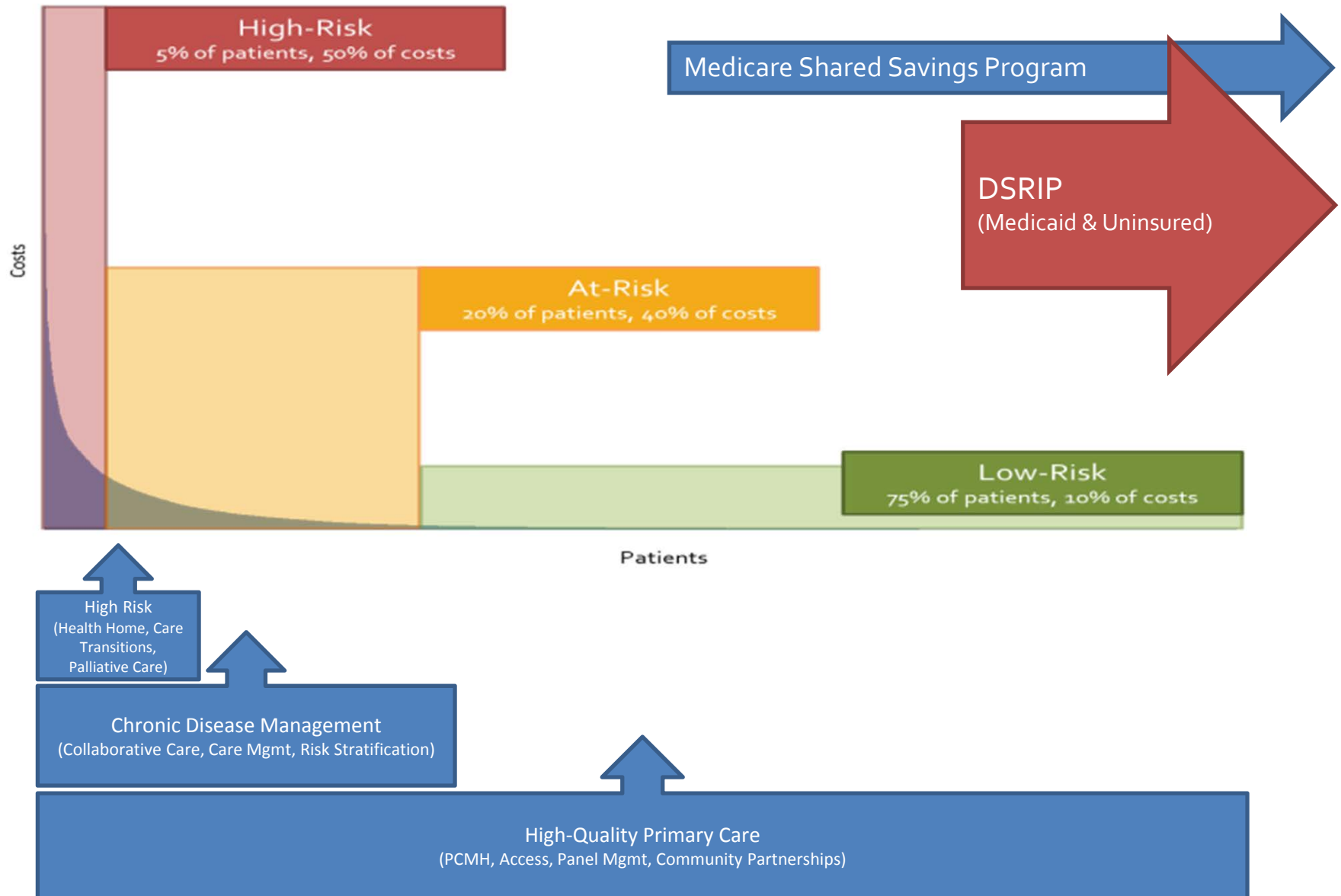
HHC ACO  
Launch



## Medicare Shared Savings Program ACO

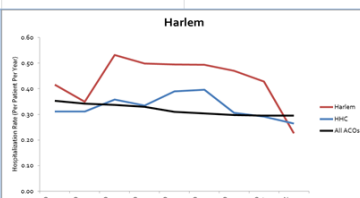
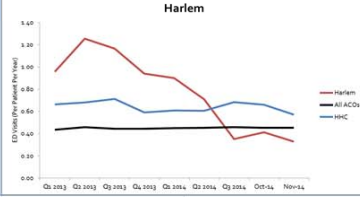
- National payment reform initiative to achieve the Triple Aim
- HHC ACO
  - 77% Dual Medicare-Medicaid Beneficiaries
  - High rates of Major Psych, HIV, Chronic Diseases compared to national benchmarks
  - Proactive Population Management Approach
- HHC ACO reduced costs by 7% and performed in 74th percentile for Quality, successfully generating shared savings in first performance year

# Aligned for Accountable Care



### HHC ACO

- Met all quality targets and reduced total costs by 7%, Hospitalizations by 9% in first performance year
- ACO Population Dashboard guides data-driven standard work, high-risk patient outreach, and performance feedback

ACO Population Dashboard								
Harlem Olumide Oyejipo								
Population	(Click for Source Data)			Performance		Links		
Total Attributed ACO Patients	626	CHF	8.9%	Hospital Admission Rate (Per Patient Per Year)	0.23		All Hospital Admissions in Last 6 months  Distribution of Hospital Facilities	10th
PCP Assigned in PAMS	69.2%	COPD	8.9%					
Major Psych	20.9%	Substance Use Diagnoses	11.3%					
ESRD	3.7%	HIV	7.7%					
Cancer	8.0%	Network Utilization Analysis	Link					
Diabetes	32.6%							
Action Items	Complete this month?			ED Visit Rate (Per Patient Per Year)	0.33		All ED Visits in Last 6 months  Distribution of ED Locations	4th
Distribute Provider Data	<input type="checkbox"/>	Click Here for Toolkit						
Review Your Highest Risk Patients	<input type="checkbox"/>	Click Here for Toolkit						
Refer Eligible Patients to Health Home	<input type="checkbox"/>	Click Here for Toolkit						
Assign All Patients to a PCP	<input type="checkbox"/>	Click Here for Toolkit						
Identify Advance Care Planning Needs	<input type="checkbox"/>	Click Here for Toolkit						
These Patients Need Appointments	<input type="checkbox"/>	Click Here for Toolkit		Population Risk Stratification		Click Here for Background and Learning Resources		
Manage Diabetic Population	<input type="checkbox"/>	Click Here for Toolkit		Risk of Hospitalization		Questions?		
Strengthen Your Outside Partnerships	<input type="checkbox"/>	Click Here for Toolkit		Overall Risk Score		Megan Cunningham, HHC ACO Director of Operations: megan.cunningham@nychhc.org		
Nick Stine, HHC ACO Medical Director: nicholas.stine@nychhc.org								

## Shared Savings Distribution for Primary Care Physicians

- ACO worked with clinical leadership and Affiliates to develop PCP list and internal distribution plan
- Proposal finalized in collaboration with Doctors Council
- Final Distribution plan approved by HHC ACO Board on February 25<sup>th</sup>, 2015
  - Even distribution for PCPs (based on FTE)
  - Applies for 2013 only, does not necessarily set precedent for possible future distributions

## Guiding Principles for Future Distributions

- Align incentives with objective measures of quality performance and patient volume
- Promote innovative population health management approaches
- Support alignment with team-based care
- Clarify place of HHC-employed physicians among participants

## **RESOLUTION**

Authorizing the President to negotiate and execute a contract extension between the New York City Health and Hospitals Corporation ("HHC" or the "Corporation") and Base Tactical Disaster Recovery, Inc. ("Base Tactical") to provide expert consulting services for disaster recovery, project management, and filing claims for reimbursement from the Federal Emergency Management Agency ("FEMA") for expenses incurred by the Corporation in connection with damages caused by Super Storm Sandy. The extension will be for a term of 12 months commencing August 1, 2015 through July 31, 2016, for an amount not to exceed \$2,500,000.

**WHEREAS**, on October 29, 2012 Super Storm Sandy caused substantial damage to numerous HHC facilities, which required the evacuation of all patients and staff from Bellevue Hospital Center and Coney Island Hospital; and

**WHEREAS**, the President of HHC issued a Declaration of Emergency and directed that repairs and replacement of facility assets necessary to have the facilities resume providing medical care to their respective communities be carried out immediately; and

**WHEREAS**, a Request for Proposals was issued November 23, 2012 and Base Tactical was the highest rated respondent and was awarded the contract for the period of February 1, 2013 through July 31, 2014; and

**WHEREAS**, said contract was extended for the period of August 1, 2014 through July 31, 2015; and

**WHEREAS**, said contract is expiring and a change of vendors at this time would jeopardize the Corporation's ability to fully recoup its expenses and to maximize its mitigation funding for the facilities impacted by Super Storm Sandy; and

**WHEREAS**, the extension of the Base Tactical contract will enable the Corporation to secure FEMA obligations, identify appropriate solutions to harden HHC facilities' physical structures so that they can resist future storms and proceed with their reconstruction; and

**WHEREAS**, the Executive Vice President and Chief Operating Officer of the Corporation shall be responsible for the overall management, monitoring and enforcement of the contract extension.

**NOW, THEREFORE** be it

**RESOLVED**, that the President be and hereby is authorized to negotiate and execute a contract extension between the New York City Health and Hospitals Corporation and Base Tactical Disaster Recovery, Inc. to provide expert consulting services for disaster recovery, project management, and filing claims for reimbursement from the Federal Emergency Management Agency for expenses incurred by the Corporation in connection with damages caused by Super Storm Sandy. The extension will be for a term of 12 months commencing August 1, 2015 through July 31, 2016, for an amount not to exceed \$2,500,000.

## EXECUTIVE SUMMARY

A contract was awarded to Base Tactical Disaster Recovery on November 6, 2012 via the President's Declaration of Emergency for the purpose of assuring that the Corporation had expert consulting services in the area of Disaster Recovery Project Management in response to the catastrophic damage caused to HHC facilities by Superstorm Sandy. The contract, which was for an amount not to exceed \$1.2 million, expired on January 31, 2013.

A Request for Proposals was issued November 23, 2012 to test the market. Base Tactical was the highest rated respondent and was awarded the contract for the period of February 1, 2013 through July 31, 2014 for Consulting Services for FEMA Related Disaster Recovery reimbursable expenses and for assuring FEMA mitigation funding. The contract was for an amount not to exceed \$4,422,700.

Base Tactical is currently in negotiations with FEMA for the provision of repairs and mitigation funding for more than \$1.7B and for reimbursement for emergency work that has been completed by the facilities. HHC requires Base Tactical's services to secure FEMA obligations, identify appropriate solutions to harden the facilities structures so they can avoid damage in future storms and proceed with their reconstruction. A change of vendors at this time would jeopardize the Corporation's ability to fully recoup its expenses and to maximize its mitigation funding for the facilities impacted by Superstorm Sandy.

It is not in the Corporation's best interest to solicit a new vendor via a Request for Proposals for Consulting Services rather than extend Base Tactical's contract for an amount not to exceed \$2,500,000. The contract extension is for a period of five years from August 1, 2015 through July 31, 2016.

Under the contract extension, Base Tactical shall perform expert consultant services in disaster management and recovery including strategic planning and project management and the finance processes involved in applying for and claiming public assistance from the Federal Emergency Management Agency (FEMA).

Base Tactical Disaster Recovery, Inc. ("Base Tactical") provides: expert consulting services for disaster response and recovery; disaster recovery project and program management; creation, submission, and management of temporary, permanent, and hazard mitigation claims to the Federal Emergency Management Agency ("FEMA"); and oversight of the New York State Office of Emergency Management grant administration. Further it reviews the Corporation's procurement of services, contractors and reimbursement processes to confirm the procedures are consistent with federal grant procedures and The Sandy Recovery Act.

# CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

**Contract Title:** Consulting Services for Federal Emergency Management Agency  
(FEMA) Related Disaster Recovery Funding

**Project Title & Number:** Consulting Services for FEMA Related Disaster Recovery Funding

**Project Location:** Bellevue, Central Office, Coler, Coney Island, Harlem,  
Health and Home Care, Kings, Metropolitan, Metro Plus,  
Neponsit

<b>Successful Respondent:</b>	Base Tactical Disaster Recovery
<b>Contract Amount:</b>	Not to exceed \$2,500,000
<b>Contract Term:</b>	August 1, 2015 through July 31, 2016

**Requesting Dept.:** Corporate Operations

**Number of Respondents:** Contract extension  
(If Sole Source, explain in Background section)

**Range of Proposals:** N/A

**Minority Business Enterprise Invited:** X Yes

**Funding Source:** X Grant: eligible for 90% FEMA and 10% CDBG (Community Development Block Grant) reimbursement

**Method of Payment:** X Other: explain Project based, not to exceed \$2,500,000

**EEO Analysis:** Approved

**Compliance with HHC's McBride Principles?** Yes

**Vendex Clearance** Pending



## CONTRACT FACT SHEET (continued)

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

A contract was awarded to Base Tactical Disaster Recovery on November 6, 2012 via the President's Declaration of Emergency for the purpose of assuring that the Corporation had expert consulting services in the area of Disaster Recovery Project Management in response to the catastrophic damage caused to HHC facilities by Hurricane Sandy. The contract expired on January 31, 2013 for an amount not to exceed \$1.2 million.

A Request for Proposals was issued November 23, 2012 to test the market. Base Tactical was the highest rated respondent and was awarded the contract for the period of February 1, 2013 through July 31, 2014 for Consulting Services for FEMA Related Disaster Recovery reimbursable expenses and for assuring FEMA mitigation funding. The contract was for an amount not to exceed \$4,422,700.

Base Tactical is currently in negotiation with FEMA for the provision of mitigation funding and for reimbursement for emergency work that has been completed by the facilities. It would create an exposure for the Corporation to change vendors at this time. A change of vendors at this time would jeopardize the Corporation's ability to fully recoup its expenses and to maximize its mitigation funding for the facilities impacted by Hurricane Sandy.

It is not in the Corporation's best interest to solicit a new vendor via a Request for Proposals for Consulting Services in this area. Therefore, the Corporation shall extend HHC Contract #CO-DIS-14-07-031, Consulting Services for FEMA Related Disaster Recovery Funding for a period of five years to secure FEMA obligations, identify appropriate solutions to harden structures for future events and proceed with reconstruction of HHC facilities.

## CONTRACT FACT SHEET (continued)

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### ***Contract Review Committee***

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

The Contract Review Committee (CRC) reviewed and approved the issuance of a Request for Proposal (RFP) on its November 21, 2012 meeting.

The original Contract was presented and approved on January 4, 2013 and the contract extension was presented and approved on January 29, 2015.

*Has the proposed contract's scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC?*

The budget will be \$2,500,000 million and the timeframe will be 12 months.

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

#### **Selection Committee Members:**

Roslyn Weinstein, SAVP, President's Office, Chair  
Alfonso Pistone, AVP, OFD  
Daniel Collins, Director/Engineering, CIH  
Frederick Covino, AVP, Budget  
Joseph Quinones, SAVP, Operations  
Michael Buchholz, AED, Coler  
Michael Rawlings, AED, Bellevue

#### **List of firms responding to RFP:**

David M Shapiro  
Jacobs  
Base Tactical  
Witt Associates  
CDM Smith/Navigant  
Resilire  
Ernst & Young  
Experis

#### **List of firms considered for Best and Final:**

Jacobs  
Base Tactical  
Witt Associates  
HHC 590B (R July 2011)

**The Selection Committee members rated each proposal and voted on weighted average based upon the following evaluation criteria (in order of priority):**

- Depth and Technical Expertise of Staff
- Sufficient Staff to complete the project within the contract term
- Ability to Work with and Educate Corporate Staff so that it can Become Self Sufficient
- Methodology that will be used to support HHC's FEMA application and claiming
- Strategy for applying for FEMA funding
- Demonstrated knowledge of hospital building infrastructure, equipment, space adjacencies and operations
- Deliverables that meet HHC's needs
- Number of Hours Assigned to Each Category Appropriate
- Allocation of the staff and expertise allow for cost effective completion of the engagement
- Hourly rates for staff reasonable

**Base Tactical received the highest rating from the Committee members.**

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

FEMA will reimburse 90% of direct administrative costs under typical circumstances. The City of New York will reimburse 10% from funding received from CDBG (Community Development Block Grants). The Corporation has submitted nearly \$150 million in costs for Emergency Protective Measures to FEMA for the initial dewatering and abatement activities needed to restore services at Bellevue, Coler, and Coney. Base Tactical will coordinate the Corporation's submittal of Project Worksheets for more than \$300M in costs for reconstruction and \$1.4 B for mitigation at Bellevue, Coler, Coney, and Metropolitan Hospitals.

Base Tactical has worked with the Hospital staff to assess the damages and catalog and video tape data needed for the Project Worksheets. In addition, the City has appropriated another \$300 million for permanent work to bring electrical and other operations back, as a down payment on expected FEMA reimbursement. In addition FEMA will provide funding to harden the facilities from future events and there is potential to secure more than \$1.4B for Hazard Mitigation.

If we assume the City appropriation number of \$300 million at 90%, the potential reimbursement is \$270 million. If we assume more current estimates including Hazard Mitigation the potential reimbursement is \$1.7 billion. FEMA both allows and encourages the use of outside experts and reimburses for their services. In sum, the Corporation would be well advised to avail itself of this much needed expertise.

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

A contract was awarded to Base Tactical Disaster Recovery on November 6, 2012 via the President's Declaration of Emergency for the purpose of assuring that the Corporation had expert consulting services in the area of Disaster Recovery Project Management in response to the catastrophic damage caused to HHC facilities by Hurricane Sandy. The contract expired on January 31, 2013 for an amount not to exceed \$1.2 million.

A Request for Proposals was issued November 23, 2012 to test the market. Base Tactical was the highest rated respondent and was awarded the contract for the period of February 1, 2013 through July 31, 2014 for Consulting Services for FEMA Related Disaster Recovery reimbursable expenses and for assuring FEMA mitigation funding. The contract was for an amount not to exceed \$4,422,700.

Base Tactical is currently in negotiation with FEMA for the provision of mitigation funding and for reimbursement for emergency work that has been completed by the facilities. It would create an exposure for the Corporation to change vendors at this time. A change of vendors at this time would jeopardize the Corporation's ability to fully recoup its expenses and to maximize its mitigation funding for the facilities impacted by Hurricane Sandy.

It is not in the Corporation's best interest to solicit a new vendor via a Request for Proposals for Consulting Services in this area. Therefore, the Corporation shall extend HHC Contract #CO-DIS-14-07-031, Consulting Services for FEMA Related Disaster Recovery Funding for a period of one year with an option to extend for one year to secure FEMA obligations, identify appropriate solutions to harden structures for future events and proceed with reconstruction of HHC facilities.

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

**Corporate staff does not have the requisite experience in such matters.**

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

**NO**

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*Contract monitoring:*

**Antonio Martin, Executive VP/COO, President's Office**

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

*Received By E.E.O.: January 2, 2013*

*Analysis Completed By E.E.O.: Approved*

By Manasses Williams, AVP, Affirmative Action

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

**TO:** David Larish  
Director Procurement System and Operations

**FROM:** Manasses C. Williams

**DATE:** January 2, 2013

**SUBJECT:** EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, BASE Tactical Disaster Recovery, Inc., has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

Minority Business Enterprise  Woman Business Enterprise  Non-M/WBE

Project Location(s): HHC's Corporate wide

Contract Number: \_\_\_\_\_

Project: Consulting services in disaster management and recovery

Submitted by: HHC's Operations department

EEO STATUS:

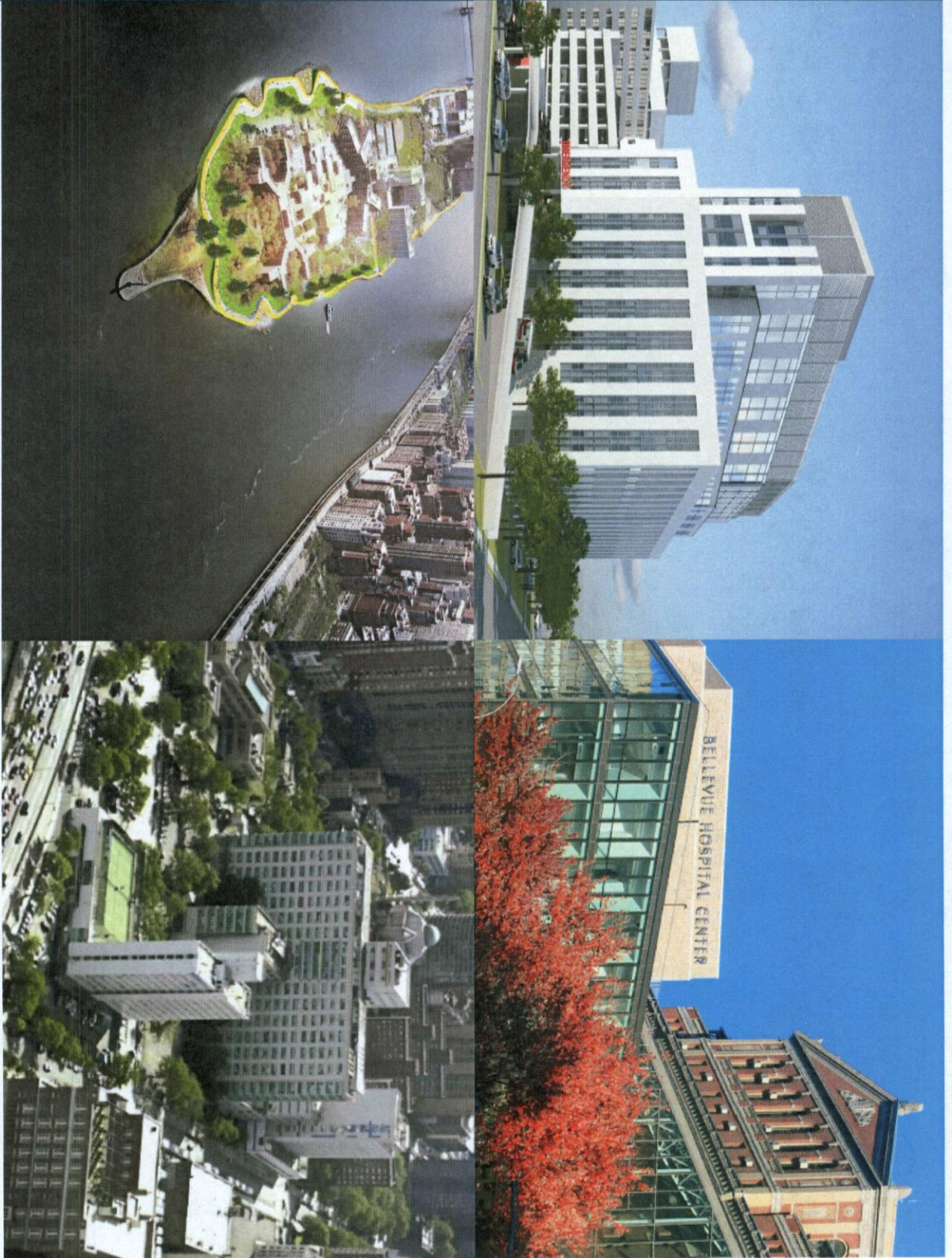
1.  Approved
2.  Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3.  Not approved
4.  Conditionally approved subject to EEO Committee Review

COMMENTS:

MCW:pat

c:

# A&E Contract Extension



**HHC** NEW YORK CITY  
HEALTH AND  
HOSPITALS  
CORPORATION

[nyc.gov/hhc](http://nyc.gov/hhc)

# A/E Services Background

- HHC procured via RFP in February 2013 for A&E services to support the projects related to Hurricane Sandy damage. From the RFP, two firms were selected to provide the necessary services. President Aviles authorized contracts not-to-exceed \$5M. In July 2013 a resolution was approved by the board of directors to increase that amount to \$11M.

ARCADIS & Parsons Brinkerhoff: Contract began April 2013 for a period of two years with a six month extension which the Corporation exercised in February 2015.

The board of directors approved an \$11.0M resolution in July 2013.

- ARCADIS – Scope of work includes: FEMA Damage Assessments, 428 Grant Applications, temporary repair design, mitigation planning, permanent design planning.
- PB – Scope of work includes: Assessment and design on specific projects (raising infrastructure)



# Architecture & Engineering

Work to be performed under this one year extension:

Continued preparation of FEMA documents to support the \$1.7B grant and environmental assessments at Bellevue, Coler, Coney Island and Metropolitan Hospitals

Design mitigation projects which include mechanical infrastructure raised to higher elevations

Design major mitigation projects including floods walls, new elevators, generator platforms and water pumping stations

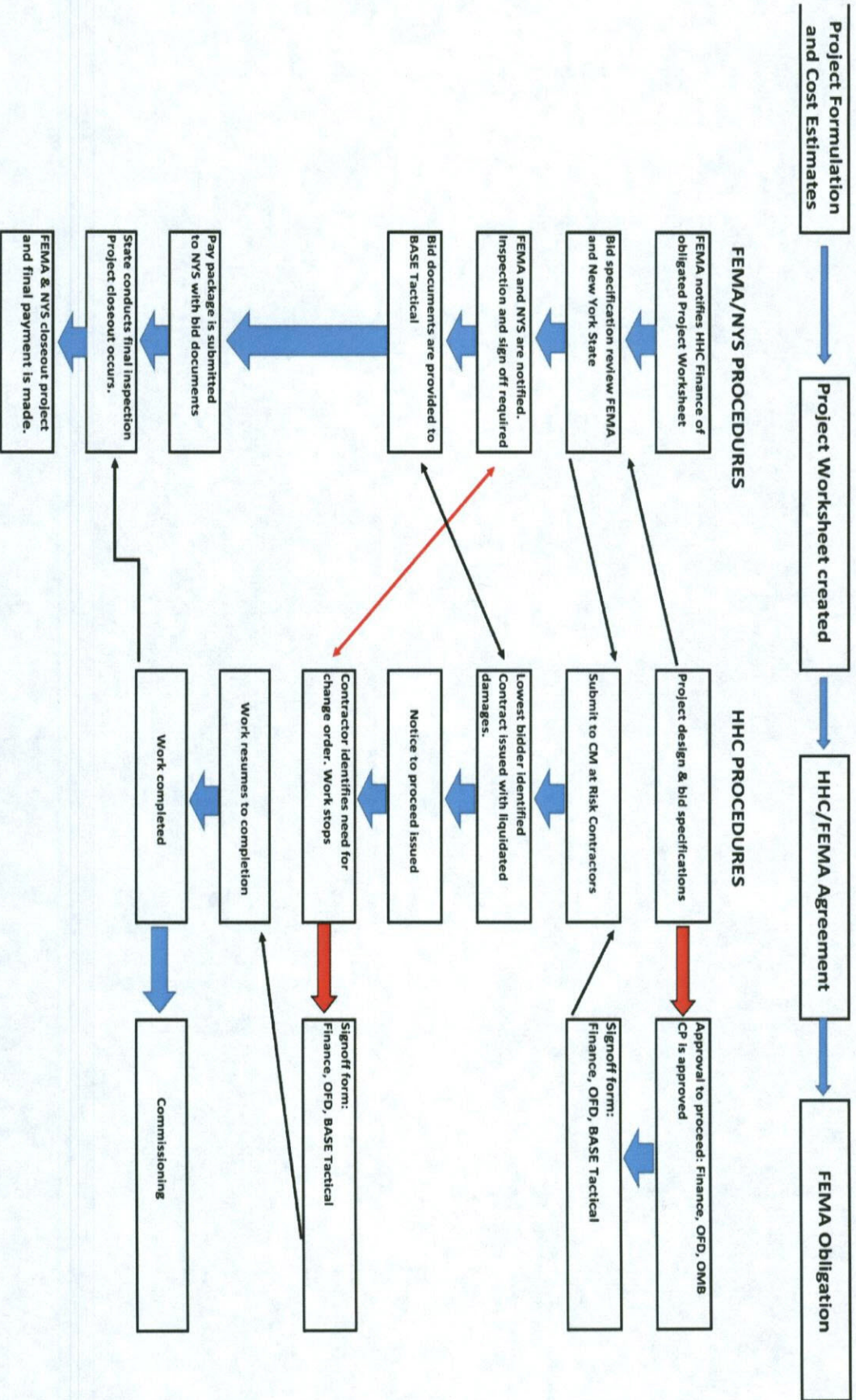
Assist in procurement packages by issuing scope and responding to bidder questions

Review and approve shop drawings

Provide overall Construction Observation activities.

# HHC PERMANENT RECONSTRUCTION PROCESS - FEMA CLAIMS

February 7, 2014



## **RESOLUTION**

Authorizing the President to negotiate and execute a contract between the New York City Health and Hospitals Corporation (HHC or Corporation) and Arcadis-U.S., Inc. and Parsons Brinckerhoff, Inc. to provide professional architectural and engineering services to assist in the recovery, reconstruction and hazard mitigation of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital and other HHC facilities, which were damaged as a result of the Super Storm Sandy disaster. The Contract will be for a term of 12 months commencing October 1, 2015 through September 30, 2016 in an amount not to exceed \$5,000,000.

**WHEREAS**, on October 29, 2012 Super Storm Sandy caused substantial damage to numerous HHC facilities, which required the evacuation of all patients and staff from Bellevue Hospital Center and Coney Island Hospital; and

**WHEREAS**, the President of HHC issued a Declaration of Emergency and directed that repairs and replacement of facility assets necessary to have the facilities resume providing medical care to their respective communities be carried out immediately; and

**WHEREAS**, a Request for Proposals was issued on February 15, 2013 seeking the services of a professional architectural and engineering services to assist in the recovery, reconstruction and hazard mitigation of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital and other HHC facilities; and

**WHEREAS**, the contracts with Parsons Brinckerhoff, Inc. and Arcadis-US, Inc., will expire as of September 30, 2015; and

**WHEREAS**, said contract is expiring and a change of vendors at this time would jeopardize the Corporation's ability to fully recoup its expenses and to maximize its mitigation funding for the facilities impacted by Super Storm Sandy; and

**WHEREAS**, the extensions of these contracts will enable the Corporation to continue to secure FEMA obligations of funds, proceed with reconstruction, and execute appropriate solutions to harden HHC facilities so that they can resist future storms.

**WHEREAS**, the Senior Vice President for Finance and Chief Finance Officer of the Corporation shall be responsible for the overall management, monitoring and enforcement of the contract.

**NOW, THEREFORE** be it

**RESOLVED**, that the President be and hereby is authorized President to negotiate and execute a contract between the New York City Health and Hospitals Corporation (HHC or Corporation) and Arcadis-U.S., Inc. and Parsons Brinckerhoff, Inc. to provide professional architectural and engineering services to assist in the recovery, reconstruction and hazard mitigation of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital and other HHC facilities, which were damaged as a result of the Superstorm Sandy disaster. The Contract will be for a term of 12 months commencing October 1, 2015 through September 30, 2016 in an amount not to exceed \$5,000,000.

## EXECUTIVE SUMMARY

New York City Health and Hospitals Corporation (“HHC”, or the “Corporation”) seeks for Parsons Brinckerhoff, Inc. and ARCADIS-US, Inc. (“the “A&E Firms”) to each provide: specialized architectural and engineering services related to damage from Super Storm Sandy, including permanent repair and hazard mitigation opportunities; propose and provide preliminary, 10%, 50%, and final designs for permanent and hazard mitigation work at Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, Metropolitan Hospital, and other Sandy affected hospitals; estimate repair, replacement, and/or hazard mitigation costs; develop cost-benefit analyses as requested; and support the Corporation’s grant applications for Public Assistance Program reimbursement by the Federal Emergency Management Agency (“FEMA”). The extension for the A&E firms will be for a term of 12 months commencing on October 1, 2015, through September 30, 2016, for an amount not to exceed \$5,000,000.

The Corporation identified a need for specialized architectural and engineering firms to design and perform work which mitigates long-term risks to life and property from natural hazards similar to hurricane Sandy. On July 25, 2013, after issuing a Request for Proposal (“RFP”) and employing a selection committee of corporate employees to review submissions from potential A&E firms, the Board of Directors of the Corporation ratified and confirmed the engagement of Parsons Brinckerhoff, Inc. and ARCADIS-US, Inc. The contracts with Parsons Brinckerhoff, Inc. and ARCADIS-US, Inc. will expire as of September 30, 2015. A change of vendors at this time would jeopardize the Corporation’s ability to fully recoup its expenses and maximize its mitigation funding for facilities impacted by Superstorm Sandy. The extensions of these contracts will enable the Corporation to continue to secure FEMA obligations of funds, proceed with reconstruction, and execute appropriate solutions to harden HHC facilities so that they can resist future storms.

# CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

**Contract Title:** Architectural & Engineering Professional Services  
**Project Title & Number:** Architectural & Engineering Professional Services  
**Project Location:** HHC Facilites  
**Requesting Dept.:** Central Office Operations

**Successful Respondent:** Arcadis-US, Inc. & Parsons Brinckerhoff, Inc.  
**Contract Amount:** Not to exceed \$5 Million  
**Contract Term:** October 1, 2015 – September 30, 2016

**Number of Respondents:** Contract Extension  
(If sole source, explain in background section)

**Range of Proposals:** \$ N/A to \$ N/A

**Minority Business Enterprise Invited:** Yes

**Funding Source:** Grant: FEMA eligible

**Method of Payment:** Time and Rate

**EEO Analysis:** Approved

**Compliance with HHC's McBride Principles?** Yes

**Vendex Clearance** Pending

(required for contracts in the amount of \$50,000 or more awarded pursuant to an RFP or as a sole source, or \$100,000 or more if awarded pursuant to an RFB.)

## CONTRACT FACT SHEET(continued)

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

During the federally declared flooding disaster of October 30, 2013, many HHC hospitals and facilities were inundated by toxic, salt, floodwaters, and storm surge for a number of days. HHC is seeking the professional services of Architectural and Engineering firms to assist in the recovery, reconstruction, and hazard mitigation of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital and other HHC facilities which were damaged as a result of the Hurricane Sandy disaster.

New York City Health and Hospitals seeks for Parsons Brinckerhoff, Inc. and ARCADIS-US, Inc. to each provide: specialized architectural and engineering services related to damage from Super Storm Sandy, including permanent repair and hazard mitigation opportunities; propose and provide preliminary, 10%, 50%, and final designs for permanent and hazard mitigation work at Bellevue, Coler, Coney Island, Metropolitan, and other Sandy affected hospitals; estimate repair, replacement, and/or hazard mitigation costs; develop cost-benefit analyses as requested; and support the Corporation's grant applications for Public Assistance Program reimbursement by the Federal Emergency Management Agency. The extension for the A&E firms will be for a term of 12 months commencing on August 1, 2015, through July 31, 2016 for an amount not to exceed \$5,000,000.

The Corporation identified a need for specialized architectural and engineering firms to design and perform work which mitigates long-term risks to life and property from natural hazards similar to hurricane Sandy. On July 25, 2013, after issuing a Request for Proposal and employing a selection committee of corporate employees to review submissions from potential A&E firms, the Board of Directors of the Corporation ratified and confirmed the engagement of Parsons Brinckerhoff, Inc. and ARCADIS-US, Inc. The contracts with Parsons Brinckerhoff, Inc. and ARCADIS-US, Inc, will expire as of September 30, 2015. A change of vendors at this time would jeopardize the Corporation's ability to fully recoup its expenses and maximize its mitigation funding for facilities impacted by Superstorm Sandy. The extensions of these contracts will enable the Corporation to continue to secure FEMA obligations of funds, proceed with reconstruction, and execute appropriate solutions to harden HHC facilities so that they can resist future storms.

## CONTRACT FACT SHEET(continued)

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### ***Contract Review Committee***

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

**The Contract Review Committee (CRC) reviewed and approved the original contract on March 20, 2013 and the contract extension on January 29, 2015.**

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

**NONE**

## CONTRACT FACT SHEET (continued)

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

The RFP was issued on February 15, 2013 and the RFP was awarded July 25, 2013.

**Selection Committee Members:**

Joseph Quinones, SAVP, Operations, Chair  
Roslyn Weinstein, SAVP, President's Office  
Alfonso Pistone, AVP, OFD  
Steven Alexander, COO, Bellevue Hospital  
Daniel Collins, Director/Engineering, CIH  
Michael Buchholz, AED, Coler  
Edie Cole, SA Director/Finance, Metropolitan Hospital

**List of Firms Responding:**

Syska Hennessy Group  
Lakhani & Jordan Engineers, PC  
CSA Group NY Architects & Engineers, PC  
Parsons Brinckerhoff  
HDR  
Goldman Copeland Consulting Engineers  
WSP Flack & Kurtz  
Greenman-Pedersen, Inc.  
STV  
Arcadis  
Stantec  
Lothrop  
Thornton Tomasetti (Not considered due not meeting submission timeframe)

The Selection Committee members rated each proposal and voted on weighted average based upon the following evaluation criteria (in order of priority):

- a. Firm's experience, organization, resources
- b. Technical qualifications
- c. Client references
- d. Management plan or program plan
- e. Cost of proposal

Acadis and Parsons Brinckerhoff received the highest rating from the Committee members.



## CONTRACT FACT SHEET (continued)

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*Scope of work and timetable:*

**Services may include but not be limited to:**

- **Recovery strategies for the affected facilities.**
- **Hazard Mitigation strategies to prevent future damage and determining funding sources which may include FEMA, HMGP 404 Section, 406 Hazard Mitigation, CDBG, Office of Management and Budget of New York City (OMB), and others.**
- **Provide bid specifications, contract documents, and engineering opinions related to the reconstruction of the damaged facilities.**
- **Provide Benefit-to-Cost analysis to support hazard mitigation projects.**
- **Provide contract administration and/or construction management services related to the reconstruction of the damaged facilities. (Note: HHC will consider alternate for Construction Administration and Construction Management firms with disaster recovery experience that have worked the A&E that is proposing. The Corporation may choose at sole option to use Johnson Controls, Inc., its current facility manager to oversee and manage the construction.**
- **Provide FEMA close-out documentations and A&E services related to the requirements of other governmental funding.**

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*Costs/Benefits:*

**FEMA will reimburse 90% of acceptable recovery costs under typical circumstances. Because of the extreme nature of Sandy the President has asked Congress to increase the level of reimbursement to 90%.**

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*Why can't the work be performed by Corporation staff:*

**Corporate staff does not have the requisite experience or expertise in such matters**

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

**No**

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

**Marlene Zurack – Senior Vice-President/Chief Finance Officer**

CONTRACT FACT SHEET (continued)

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

Received By E.E.O. February 2013  
Date

Analysis Completed By E.E.O.

April 9, 2013 & September 16, 2014

Date

Manasses Williams


Name

31647A

Manasses C. Williams  
Assistant Vice President  
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: David Larish, Director  
Procurement Systems and Operations  
Division of Materials Management

FROM: Manasses C. Williams 

DATE: January 30, 2015

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

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

Minority Business Enterprise  Woman Business Enterprise  Non-M/WBE

Project Location(s): Corporate-wide

Contract Number: \_\_\_\_\_

Project: Professional Engineering and Architectural Services

Submitted by: Division of Materials Management

EEO STATUS:

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

COMMENTS:

MCW/srf

31667B

**Manasses C. Williams**  
Assistant Vice President  
Affirmative Action/EEO

manasses.williams@nychhc.org

**TO:** David Larish, Director  
Office of Procurement Systems and Operations

**FROM:** Manasses C. Williams

**DATE:** February 13, 2015

**SUBJECT:** EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

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

Minority Business Enterprise  Woman Business Enterprise  Non-M/WBE

Project Location(s): Corporate-wide

Contract Number: \_\_\_\_\_

Project: Professional Services

Submitted by: Office of Procurement Systems and Operations

EEO STATUS:

1.  Approved
2.  Approved with follow-up review and monitoring
3.  Not approved
4.  Board Conditional

COMMENTS:

MCW:srf