

BOARD OF DIRECTORS MEETING
THURSDAY, MARCH 20, 2014
A-G-E-N-D-A

<p>Call to Order - 4 pm</p> <p>1. Adoption of Minutes: February 27, 2014</p> <p><u>Acting Chair's Report</u></p> <p><u>President's Report</u></p> <p>>>Action Items<<</p> <p><u>Corporate</u></p> <p>2. RESOLUTION Authorizing the President of the New York City Health and Hospitals Corporation to execute a 99-year sublease with CAMBA Housing Ventures, Inc. or a not-for-profit housing development fund corporation in which CHV is the sole member, or a limited partnership or limited liability company in which the general partner or managing member, as applicable, is an affiliate of CHV for the development of low-income housing, and housing for the formerly homeless on the site of the "G Building," a parcel of land on the campus of Kings County Hospital Center of approximately 97,000 square-feet at a fair market value rent established by appraisal which is currently anticipated to be not more than \$2.5 Million in total. <i>(Capital Committee – 03/13/2014)</i></p> <p><u>Committee Reports</u></p> <ul style="list-style-type: none"> ➤ Audit ➤ Capital ➤ Community Relations ➤ Finance ➤ Strategic Planning <p><u>Subsidiary Board Report</u></p> <ul style="list-style-type: none"> ➤ MetroPlus Health Plan, Inc. <p><u>Facility Governing Body / Executive Session</u></p> <ul style="list-style-type: none"> ➤ Coler Nursing Facility ➤ Goldwater Specialty Hospital and ➤ Goldwater Nursing Facility (nka Henry J. Carter Specialty Hospital and Nursing Facility) <p>Semi-Annual Report (Written Submission Only)</p> <ul style="list-style-type: none"> ➤ Woodhull Medical & Mental Health Center <p>>>Old Business<< >>New Business<<</p> <p>Adjournment</p>	<p>Rev. Lacey</p> <p>Rev. Lacey</p> <p>Mr. Aviles</p> <p>Ms. Youssouf</p> <p>Ms. Youssouf Ms. Youssouf Mrs. Bolus Mr. Rosen Mrs. Bolus</p> <p>Mr. Rosen</p> <p>Rev. Lacey</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 27th of February 2014 at 4:00 P.M. pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Reverend Diane E. Lacey
Mr. Alan D. Aviles
Josephine Bolus, R.N.
Dr. Jo Ivey Boufford
Ms. Kathleen Carlson
Dr. Vincent Calamia
Dr. Herbert F. Gretz, III
Ms. Anna Kril
Mr. Robert F. Nolan
Mr. Mark Page
Mr. Bernard Rosen

Andrea Cohen was in attendance representing Dr. Lilliam Barrios-Paoli, and Dr. Amanda Parsons was in attendance representing Dr. Mary Bassett, each in a voting capacity. Reverend Lacey chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on January 30, 2014 were presented to the Board. Then, on motion made by Reverend Lacey 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 30, 2014, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

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

Reverend Lacey announced the appointment of HHC's newest Board Member, Dr. Mary Bassett, Commissioner of the Department of Health and Mental Hygiene. She stated that Dr. Bassett will attend the next Board meeting.

Reverend Lacey announced that Dr. Adam Karpati and Andrea Cohen are leaving New York City employment and HHC's Board of Directors. She thanked them both for their contribution to HHC's Board and wished them well in their future pursuits.

Reverend Lacey updated the Board on approved and pending Vendex.

On behalf of the Board of Directors of HHC, Reverend Lacey thanked the staff of HHC for their tireless effort and dedication to our patients during the recent snow emergencies.

Finally, Reverend Lacey announced that a public hearing is scheduled for Thursday, March 6, 2014 to discuss a proposed long-term lease between HHC and CAMBA Housing Ventures Incorporated. The lease is for the development of affordable and supporting housing on the campus of King County Hospital Center.

PRESIDENT' S REPORT

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

Mr. Aviles expressed his gratitude to Andrea Cohen and Dr. Adam Karpati for their contribution to the Corporation.

ACTION ITEMS

RESOLUTION

2. Authorizing the President of the New York City Health and Hospitals Corporation to **purchase computer workstations, laptops, and IT peripherals for the entire Corporation** through Third Party Contracts(s) from various vendors on an on-going basis in an amount not to exceed \$7,200,000, over a 12-month period, which includes a 10% contingency of \$654,545.50.

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

RESOLUTION

3. Authorizing the President of the New York City Health and Hospitals Corporation to **purchase networking hardware, software, and associated maintenance** from various vendors on an on-going basis via Third Party Contract(s) in an amount not to exceed \$7,200,000 for a one year period, which includes a 10% contingency of \$654,545.50.

Mr. Aviles 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 **purchase networking hardware, software, and associated maintenance** from various vendors via Third Party

Contracts on an on-going basis in an amount not to exceed \$28,300,000 in capital funds for a networking infrastructure refresh program over a two-year period.

Mr. Aviles 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 initiate the planning for a **construction program of improvements** throughout the Corporation **to support an information technology equipment modernization and replacement plan** with upgrades to heating, ventilation and air conditioning and electrical equipment at a total approximate cost of \$15 million over the next two years subject to further authorization by the Capital Committee of the components of such construction program.

Mrs. Bolus 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 **New York Legal Assistance Group** for part-time, non-exclusive use and occupancy of space at **Bellevue Hospital, Coler Nursing Facility, Coney Island Hospital, Elmhurst Hospital Center, Harlem Hospital Center, Henry J. Carter Specialty Hospital & Nursing Facility, Jacob Medical Center, Kings County Hospital Center, Lincoln Medical & Mental Health Center** to provide legal services to patients and training to Corporation staff at an annual fee of \$55,000 per clinic, per facility year one and two and \$60,000 per clinic, per facility, year three, four and five payable by the Corporation to the Licensee and without any payment by the Licensee for the use of the space.

Randy Retkin, Director of Legal Health, New York Legal Assistance Group, explained that they provide on-site, free legal services for patients who go to clinics at HHC facilities.

She provided the Board with a summary of the different types of populations they serve, as well as the types of legal issues they deal with, including health insurance assistance and housing assistance.

Mr. Salvatore Russo, Senior Vice President and General Counsel, added that HHC has a long relationship with Legal Health, who have been good partners with us in helping the patients that we serve.

Mrs. Bolus moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

BOARD COMMITTEE AND SUBSIDIARY BOARD REPORTS

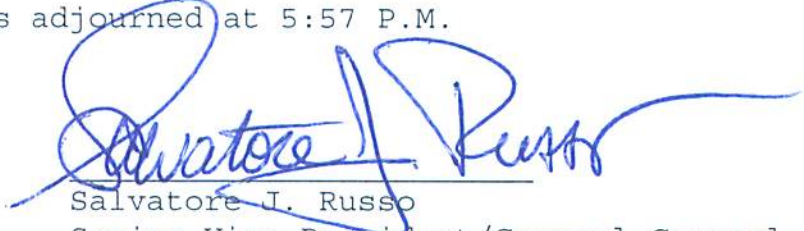
Attached hereto is a compilation of reports of the HHC Board Committees that have been convened since the last meeting of the Board of Directors. The reports were received by the Chairman at the Board meeting.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Reverend Lacey reported that the Board of Directors as the governing body of Lincoln Medical and Mental Health Center and Gouverneur Healthcare Services were reviewed, discussed and adopted the facilities reports presented; and reviewed and accepted the semi-annual written report for Queens Hospital Center.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 5:57 P.M.



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

COMMITTEE REPORTS

Capital Committee – February 13, 2014 As reported by Ms. Emily Youssouf

Senior Assistant Vice President's Report

Roslyn Weinstein, Senior Assistant Vice President, Office of the President, advised of an upcoming Public Hearing and provided an overview of the meeting agenda. Ms. Weinstein announced that a Public Hearing would be held to discuss a proposal by CAMBA Housing Ventures, for development of affordable and supportive housing to be located on Kings County Hospital campus, where the "G" Building is currently located. The development would feature 293 units of housing for homeless and special needs households; including patients from Brooklyn Hospitals and Nursing Homes. She noted that current CAMBA housing, on the Kings County campus, had been going well. This development would be a continuation of CAMBA Gardens Phase I, completed in October 2013, which features 209 units of affordable housing, located on site of the former "J" and "N" buildings. She noted that the Public Hearing would take place on March 6, 2014 and would be held on the Kings County campus, further details would be provided as they were finalized.

Ms. Youssouf asked if HHC had received a plan from CAMBA, including financing. Ms. Weinstein said that there was a preliminary plan but she had not seen financing information. Ms. Youssouf asked that the information be shared with Committee members.

Josephine Bolus, RN, expressed concern that affordable housing projects often leave needy individuals out. Individuals that fall in between income levels need help as well. Ms. Youssouf agreed and asked how flexible the City will be in creating the income bands. She noted that a new administration was in place in the City and so discussions may be productive. Jeremy Berman, Deputy General Counsel, said he believed that there was already discussion about expanding the bands, which would include more HHC patients and staff. Ms. Youssouf again stated that she would like to be kept fully informed.

Mrs. Bolus said that there were previous HHC employees that were in fact living in shelters because they fell outside of the income levels and that was a problem that needed to be addressed. Ms. Youssouf asked that a meeting or call be scheduled for further discussion of the project and to form a strong argument for dealing with these issues.

In conclusion, Ms. Weinstein advised that action items on the agenda included a license agreement with the New York Legal Assistance Group, and a resolution concerning improvement of the Corporate Wide IT infrastructure.

That concluded her report.

Action Items:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year revocable license agreement with the New York Legal Assistance Group (the "Licensee") for part-time, non-exclusive use and occupancy of space at Bellevue Hospital Center, Coler Nursing Facility, Coney Island Hospital, Elmhurst Hospital Center, Harlem Hospital Center, Henry J. Carter Specialty Hospital & Nursing Facility, Jacobi Medical Center, North Central Bronx, Kings County Hospital Center, Lincoln Medical & Mental Health Center, Metropolitan Hospital Center, Queens Hospital Center and Woodhull Medical & Mental Health Center (the "Facilities") to provide legal services to patients and training to Corporation staff at an annual fee of \$55,000 per clinic, per facility year one and two and \$60,000 per clinic per facility year, three, four and five payable by the Corporation to the Licensee and without any payment by the Licensee for the use of the space.

Dion Wilson, Assistant Director, Office of Facilities Development, read the resolution into the record. Mr. Wilson was joined by Randy Retkin and Julie Brandfield, New York Legal Assistance Group (NYLAG).

Ms. Youssouf noted that the relationship with NYLAG had been very positive for HHC and expressed excitement in the expansion of services being discussed.

Ms. Retkin thanked HHC for having been such a great partner over the years, and proceeded to review a power point presentation documenting accomplishments made over the course of the previous agreements.

Ms. Retkin explained that LegalHealth had become an integral member of HHC's healthcare team providing patients with free legal services that assist with safe discharge, access to treatment and improved quality of life. Over the past three (3) years LegalHealth handled 7,064 legal matters for 4,781 patients of eight (8) HHC hospitals. Expansion to three (3) additional HHC facilities and an increase in legal clinics at existing facilities would allow LegalHealth in partnership with HHC to continue to combat the social determinants of health.

Ms. Retkin noted that LegalHealth held weekly half day free legal clinics onsite at five (5) partnering HHC Hospitals; Coler-Goldwater Specialty Hospital and Nursing Facility (new clinic as of July 2012), Harlem Hospital Center, Jacobi Medical Center & North Central Bronx Hospital, Kings County Hospital Center, and Lincoln Medical Center; and twice weekly half day free legal clinics onsite at three (3) partnering HHC Hospitals; Bellevue Hospital Center, Elmhurst Hospital, and Woodhull Medical Center. On average, six (6) patients per clinic with 1.5 legal matters were dealt with. She explained that each legal clinic had 50% of an attorney's time dedicated to the clinic and to the legal work arising from these referrals, including court appearances, legal research, legal drafting, and/or preparation of immigration filings.

Ms. Retkin noted that 520 matters were intaked and screened for eligibility for immigration relief that could lead to Medicaid, 89 for USCIS Freedom of Information Act requests to determine if patient has an immigration history that may make them Medicaid eligible, or that would rule out filing any further immigration applications, and 24 matters for visa extensions to allow for continuation of vital medical care, or for a family member to extend their stay in the U.S. to care for a seriously ill patient. In total, LegalHealth worked to increase or maintain health insurance for 773 HHC patients.

Prior data exchanges completed in 2011 show the direct financial impact of LegalHealth's work, such as when a client becomes eligible for or maintains Medicaid. Examples were as follows; \$409,133 in insurance reimbursements to Bellevue over three years, \$263,368 in reimbursements to Jacobi over three years, and \$217,131 in reimbursements to Elmhurst over three (3) years.

Ms. Retkin advised that as a result of legal intervention, Alternative Level of Care patients had been moved to nursing homes, assisted living, or other places in the community with home care. In the past year, LegalHealth had worked closely with Bellevue, Kings, Jacobi and most recently Elmhurst to evaluate patients, including ALOC patients, for capacity to pursue legal remedies where appropriate. Patients without capacity were flagged for possible Article 81 Guardianship.

Ms. Retkin advised that the proposed expansion would take LegalHealth's presence from eight (8) hospitals with 11 clinics to 11 hospitals with 16 clinics, representing a 45% increase in services offered. She stated that hospitals have expressed a willingness to spread NYLAG fundraising dollars and increase costs to hospitals to allow expansion, and as a result of spreading foundation dollars among a larger number of legal clinics, hospital contribution was increasing to \$55,000 per clinic for years one (1) and two (2) and \$60,000 per clinic for years three (3) through five (5).

Ms. Youssouf reiterated that the relationship was of great benefit to the Corporation and thanked Ms. Retkin for coming.

There being no further questions or comments, the Committee Chair offered the matter for a Committee vote and the resolution was approved for the full Board's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to initiate the planning for a construction program of improvements throughout the Corporation to support an information technology equipment modernization and replacement plan with upgrades to heating, ventilation and air conditioning ("HVAC") and electrical equipment at a total approximate cost of \$15 Million over the next two years subject to further authorization by the Capital Committee of the components of such construction program.

Peter Lynch, Senior Director, Office of Facilities Development, read the resolution into the record. Mr. Lynch was joined by Bert Robles, Senior Vice President/Chief Information Officer, and Sal Guido, Assistant Vice President, Enterprise Information Technology Services (EITS).

Mr. Guido narrated a power point presentation. He advised that in order to support new technologies, initiatives and increasing network infrastructure the Enterprise Information Technology Services (EITS) Group developed a Network Refresh Program, for which in February 2011, the Board of Directors approved a capital spend of \$25.3 million for the 1st Wave of the ON-GOING Network Infrastructure Refresh Program. The goal of the program was aligning with industry standards to refresh network infrastructure equipment between 3 to 5 years.

Mr. Guido explained that this program was needed in order to support new initiatives and technologies such as: a new clinical EMR/Meaningful Use, Financial Enterprise Resource Planning (ERP) System Replacement/ Upgrade, Sorian (Siemens Registration System), Business Intelligence, IP Telephony, Picture Archiving and Communication System (PACS). These systems and several others require a robust data communication system in order to operate efficiently.

EITS Completed Wave 1 in the 4th Quarter of 2013. Sites completed: LAN at Queens, Elmhurst, Lincoln, Harlem, Woodhull, Cumberland and Belvis, and Wireless at Queens, Elmhurst, Lincoln, Woodhull and Cumberland.

Ms. Youssouf asked if the wireless mentioned was free wireless. Mr. Guido explained that it was guest wireless for patients and resources within the hospitals. Ms. Youssouf asked if users would enter a code to log on. Mr. Guido said users would register with their personal email address and would then have access to certain aspects of the internet, excluding questionable content.

Mrs. Bolus asked if users would be able to watch television shows utilizing the network. Mr. Guido said yes, they would be allowed to access all available content, but HHC had to be aware of how the back end intranet infrastructure could handle the bandwidth utilization. Mr. Robles explained that guest traffic would be separate from regular hospital traffic so as to not interfere with critical facility utilization.

Mrs. Bolus asked if this was throughout the facilities. Mr. Guido said yes.

Mr. Guido explained that Wave 2 of the program would encompass LAN at Jacobi Medical Center and North Central Bronx Hospital. The \$15 million that Capital Committee was being asked to approve in this resolution would be the next line item, and it would be mostly for environmental at Queens, Elmhurst, Jacobi, and NCB.

Ms. Youssouf asked for an explanation of Voice Over Internet Protocol (VOIP). Mr. Guido explained that it would allow for telephone systems to be upgraded for higher technology with more flexibility, such as patient care services and video on demand for remote patients. Mr. Robles explained that productivity could be improved on a local level by retiring old exchanges and utilizing newer technologies such as combined voice/data lines. It was anticipated that in the next five (5) to seven (7) years all old exchanges would be retired.

Ms. Youssouf asked if the upgrade would allow for money saving. Mr. Guido said yes, combining the services into a single wire will reduce the cost considerably. Instead of running three (3) independent networks, they would be run as one (1).

Ms. Youssouf asked if capacity would be affected with the addition of guest wireless and what impact on utilization that would have. Mr. Guido said it will be monitored but the amount of streaming that takes place is far greater than simple data transfers.

Mrs. Bolus asked if wires had already been replaced. Mr. Guido explained that fiber-optic upgrades had been completed, and noted that systems allowing for temporary housing of streams can be done internally to eliminate or minimize outgoing traffic.

Mrs. Bolus asked if HHC could direct users to HHC preferred sites or information. She also asked if there were concerns about protecting HHC sites and information. Mr. Robles explained that security had been upgraded immensely in the past few months, monitoring traffic and data, and intrusion prevention is in place. However, he noted, there were always new ways of hacking so HHC was constantly on guard. Mr. Robles explained that the segmented networks should also prevent problems. Utilizing the guest network does not allow access to the main HHC site so a hacker would have to exit the guest site and come back around. The Corporation is constantly reviewing and discussing cyber-protections, he said.

Ms. Youssouf asked if the \$43 million was included in the overall budget. Mr. Guido said yes. Ms. Youssouf asked if that money completed just the environmental. Mr. Robles said it covers environmental, upgraded LAN at Jacobi and NCB, wireless at NCB and Jacobi and VOIP at Coney, Queens, Elmhurst, Jacobi and NCB.

Ms. Youssouf asked about the IT closets and how that process was going. Mr. Lynch explained that this authorization would allow for an architectural/engineering firm to be engaged, which would advance designs to the point of bid/solicitation.

Ms. Youssouf asked that all work be completed above flood levels. The gentlemen said it would be.

Mr. Guido explained that multiple solicitations would be conducted via NYS OGS and GSA contracts to procure networking equipment and professional services. A minimum of three resellers will be solicited for each purchase. A purchase order will be issued to the lowest responsive and responsible bidder for each purchase.

Ms. Youssouf asked about project contingencies. Mr. Guido said that there was a 10% contingency.

Mrs. Bolus asked if small business would be participating in any of the work. Mr. Lynch explained that the construction component would operate within Equal Employment Opportunity (EEO) guidelines, as usual.

There being no further questions or comments, the Committee Chair offered the matter for a Committee vote and the resolution was approved for the full Board's consideration.

Information Items - Project Status Report

Southern Brooklyn/Staten Island Health Network

Peter Lynch, Senior Director, Office of Facilities Development, provided a delay report on the Boiler project at Coney Island Hospital.

Mr. Lynch explained that the Boiler Replacement project, after initial delays as a result of newly implemented flood level mandates, was moving along nicely, with one new boiler on site, and the other in place. Ms. Youssouf asked whether the boilers will be above flood levels. Mr. Lynch said that they met the 100 year flood plan but not the 500 year flood plan.

Mrs. Bolus asked about a New York State Law that she understood negatively impacted the hiring of minorities. Mr. Berman explained that the law might negatively impact small business because insurance rates are increased. Mrs. Bolus said thank you.

Ms. Youssouf asked if the Sea View project was complete. Mr. Lynch said the project was not significantly delayed, and therefore not due for a report, but he would provide status information to the Committee.

Community Relations Committee – February 4, 2014
As reported by Josephine Bolus, RN

CHAIRPERSON'S REPORT

Mrs. Bolus welcomed members of the CRC and invited guests.

Before proceeding with the annual activity reports for the Year 2013 from the Community Advisory Boards in the South Manhattan Network; Mrs. Bolus highlighted some notable developments that had occurred since the November meeting.

Mrs. Bolus reported that the final three Annual Public Meetings of the Board of Directors for Fiscal Year 2014 had been held in Queens on November 25th at Elmhurst Medical Center; in Brooklyn on November 26th at Woodhull Medical and Mental Health Center; and in Manhattan on December 9th at Bellevue Hospital Center.

Mrs. Bolus informed the Committee that the Board Members had been reviewing all of the testimonies given and that there would be written responses.

Mrs. Bolus stated that the Board Members had been particularly heartened by the testimonies of Community Advisory Board's chairpersons and members. She noted that the Council of Advisory Boards Chair and Kings' County CAB Chairperson Agnes Abraham had appeared at both the Brooklyn and Manhattan meetings. Reflecting the general tenor of the meetings, Ms. Abraham said, "We need to view HHC's employees who contribute to the organization's remarkable achievements, and who will help it overcome its challenges, as many fingers on the same hand..."

Mrs. Bolus reported that, at the Brooklyn meeting, Ms. Abraham had raised concerns about the extensive waits for appointments at the dental clinic and long lines in the pharmacy at Kings County Hospital.

Mrs. Bolus stated that there had been testimony given at most of the borough meetings by representatives, most of them local facility staff, of the labor organizations representing HHC nurses, resident physicians, Local 420/AFSCME, and others.

Mrs Bolus reported that, at the Queens meeting, four members of the Elmhurst CAB, Peter Amato, Salua Baida, Eartha Washington and Nancy Wang, had expressed a range of concerns including:

- The need for the expansion of services associated with the new Elmhurst Women's Healthcare Services Pavilion, which is scheduled to open in 2014;
- The need for greater primary care services; and
- The importance of language access services.

Mrs. Bolus reported that, at the Brooklyn meeting, Ms. May Thomas, Dr. Susan Smith McKinney Nursing and Rehabilitation Center (DSSM) CAB Chair, had described the CAB's work on the voter registration campaign. In her remarks, Ms. Thomas had also thanked HHC for its efforts thus far in its collaboration with housing providers to create affordable housing on the Kings County campus. In addition, Ms. Thomas had emphasized the great need for more affordable housing, particularly for DSSM and Kings County Hospital patients. Mrs. Bolus reported that Ms. Jacqueline Narine, Cumberland D&TC CAB Chair, had identified the need for equipment and improvement in customer service. Mr. Talib Nicheren, Woodhull CAB Chair, among others, had identified concerns about challenges to access to care in North Brooklyn and the potentially adverse impact on HHC facilities if area voluntary hospitals were to close.

Mrs. Bolus stated that she personally appreciated Ms. Debra Greif's, Chairperson of the Brooklyn Family Services Advisory Council recognition of HHC's work to better serve patients with developmental disabilities.

Mrs. Bolus reported that, at the Manhattan meeting, Ms. Gladys Dixon, Coler CAB Chair, had strongly urged that HHC's Board give a greater focus on the long term care facilities and expressed concern about the future of Coler Specialty Hospital and Nursing Facility. Mrs. Bolus had

quoted: "We have so many rich people coming to live on Roosevelt Island, and we are the poor." Mrs. Bolus reported that Coler CAB member, Ms. Judith Berdy, had expressed concerns about the future staffing at Coler because of its status now as a nursing and rehabilitation facility and is no longer a long term care acute hospital. Ms. Berdy had noted that Coler had more than 800 very challenging patients, and that it was imperative that there be a level of staffing that ensures that all patients' needs be met.

Mrs. Bolus reported that Ms. Bette White, Chair of the Harlem Hospital Center CAB, had hailed the opening of the hospital's new Emergency Department in January. Ms. Jewel Jones, Metropolitan Hospital CAB Chair, had praised the facility's work to improve access through enhanced capacity of its primary care teams and the implementation of Project RED which was resulting in reduced readmissions for heart failure patients. Mr. Ed Shaw, Vice Chair of the Metropolitan CAB, had said that with limited funds, Metropolitan Hospital was doing an excellent job. However, in his remarks, Mr. Shaw had noted that the Neurology Department could better serve its patients if there were more primary care physicians or nurse practitioners; to reduce the wait time. Mr. Bobby Lee, Bellevue CAB Chair, had recognized home care and outreach programs conducted by the hospital, however he had suggested that improvement was needed in the area of "customer service" throughout the facility. Mrs. Bolus noted that Mr. Lee had specifically suggested that a highly visible directory of all services and programs be posted. Ms. Sandra Stevens had noted that Bellevue has a unique capability to serve special needs children.

Mrs. Bolus reported that former Bellevue CAB member, Ms. Sandy Hecker, had called for training and new operating procedures for the main switchboard staff, so that all patients attempting to schedule appointments with their doctors would be given accurate information. In addition, Ms. Hecker had stated that hospital leadership should review processes in place to ensure that more responsive interventions occurred with patients who are in distress in and around the Emergency Room.

Mrs. Bolus reported that, at the Bellevue meeting, there had been more than a dozen individual staff members who have provided testimonies. She stated that social worker members of Local 768 of DC 37 had read a joint statement urging pay increases for better staff retention. Mrs. Bolus noted that their statement also had sought leadership's focus on addressing problems identified by psychiatric social work and nursing staff. Mrs. Bolus reported that housekeeping and environmental services workers had raised concerns about the outsourcing of those services. In particular, they had raised issues about the lack of supplies, inadequate staff coverage for the size and needs of a facility like Bellevue and possible retaliation by the contract agency management because they had been speaking out at the Board's public meeting.

Mrs. Bolus reported that Mr. Anthony Feliciano, Executive Director of the Commission on the Public's Health System (CPHS), had spoken about spending reductions, layoffs, services consolidations and a movement toward the privatization of important direct and non-direct patient services. Mrs. Bolus quoted: "communities and labor must be part of the decision-making process at HHC for any changes". In addition, Mrs. Bolus stated that Mr. Feliciano had suggested a "communication and public education plan to inform patients and community members of any changes".

Mrs. Bolus reported that Ms. Judy Wessler, founder and former Executive Director of CPHS, identifying herself as a consumer, had stated that she wanted more to come out of the Annual Public Meetings. Also, Ms. Wessler had expressed concern about the HHC transition with the change in City administration, which, she had noted, has been the focus of a memorandum she had written with Board Vice-Chairperson Reverend Diane Lacey. Moreover, Ms. Wessler had added that, as an HHC patient, she had been personally experiencing long waits for specialty care appointments.

Mrs. Bolus reported that, at each of the public meetings, Ms. Ann Bove, Bellevue RN, President of the HHC Executive Council and Secretary of the New York State Nurses Association had spoken about the need for adequate staffing and articulated concerns about outsourcing. Ms. Bove had urged that impact on direct patient care be foremost in the Board's review of any cost-containment initiatives. In addition, Ms. Grace Otto, who had identified herself as an RN at Bellevue for 29 years, had stated that the HHC Press Ganey staff survey results had illustrated, that "too often, management fails to listen to what we have to say." In her remarks, Ms. Otto had also stated that joint labor management meeting decisions and plans were often not executed.

Mrs. Bolus reported that, at the Manhattan meeting, nursing staff speaking as leaders and members of the State Nurses Association had cited concerns about workload, crowding, access to care, and bed availability. They had spoken about potential risks of outsourcing or "privatization" and of the widespread hiring of agency nurses. In addition, they had talked about the need for better communication and sharing of responsibilities at all levels and for more support for staff initiative and input.

Mrs. Bolus reported that the Committee of Interns and Residents had spoken of their efforts to gain recognition as a union with the Queens and Elmhurst hospital's academic affiliate, Mount Sinai Medical Center; and they had sought HHC's support in this endeavor. Mrs. Bolus noted that clearly, the HHC Board has much to consider as we move forward in 2014.

Mrs. Bolus reported on another matter, the influence that a CAB can have on changing public policy has been demonstrated recently. She stated that some Bellevue CAB members, for a long time, have urged the banning of styrene disposal products' use at HHC facilities. Ms. Michelle Winfield, a leader in this effort, in a written statement for the Board's Manhattan Annual Meeting, had reiterated the CAB's call for such a ban. On February 27, 2013, the CAB had adopted a resolution which not only had called for the ban of such products at Bellevue and other HHC facilities, but also had called for passage by the City Council of legislation banning or restricting polystyrene food packaging across the City. Mrs.

Bolus stated that the CAB's resolution had been on a Council Committee agenda since May 2013. She noted that, at its last legislative session last year, on December 19, 2013, the City Council had unanimously passed legislation prohibiting restaurants, food carts and stores from selling or providing food in items made from polystyrene.

Moreover, one of the final bills that Mayor Bloomberg had signed into law before leaving office would require the Department of Sanitation to study whether polystyrene products can be effectively recycled. This study will be conducted over the next 12 months. If it is determined that polystyrene products cannot be effectively recycled, then food service establishments will be banned from using them beginning July 1, 2015. Not-for-profit institutions that use these products can apply for a hardship waiver if they can show that no comparable product exists that is the same price or cheaper than polystyrene. Mrs. Bolus noted that Bellevue has, for some time, with the exception of hot beverage cups, discontinued use of polystyrene products.

Before concluding her remarks, Mrs. Bolus shared other notable occurrences since the last Community Relations meeting:

- On Sunday November the 24th and Monday the 25th, more than 200 patients have been relocated without a hitch from Goldwater to the new Henry J. Carter Specialty Hospital and Nursing Facility in Harlem. We are looking forward to the formation of the new Henry J. Carter Community Advisory Board.
- From December 8th through the 13th, the Joint Commission had conducted its triennial survey at Harlem Hospital Center. At the conclusion of the survey, the surveyors had commented that "Harlem is a premier HHC facility with clinical and frontline staff that is competent, compassionate, caring, enthusiastic, involved and engaged." CAB Chair, Ms. Bette White, had participated in the survey leadership session.
- In December, Kings County Hospital Center's Opioid Treatment Program had received a national "Science and Service Award" from the Federal Substance Abuse and Mental Health Services Administration for its 95% retention rate for patients in the 30-day treatment program. Remaining in the program dramatically increases patients' chances of recovery from addiction.

Mrs. Bolus sadly announced that Dr. John W. V. Cordice had passed away on December 29th at the age of 95. She stated that Dr. Cordice was co-leader, on September 20, 1958, with Dr. Aubre C. Maynard, of the Harlem Hospital Center team of surgeons who had saved Dr. Martin Luther King after a life-threatening stab wound. Mrs. Bolus added that Dr. Cordice had continued to live in Harlem and practiced medicine for more than 40 years. She added that the HHC family had extended its sympathies to Dr. Cordice's family and friends, and thanked him, one last time, for his noble service.

Moving to more uplifting news, Mrs. Bolus extended congratulations to Ms. Lynda Curtis, Senior Vice President of the South Manhattan Network, who will be retiring on March 2nd. Mrs. Bolus informed the Committee that Ms. Curtis had provided 40 years of unparalleled service to HHC and its patients. She added: "Well done – Lynda! You will be missed by the CABS, the Board and your colleagues."

In introducing Mr. Aviles for his remarks this evening, Mrs. Bolus took the opportunity to express her personal appreciation of his extraordinary leadership. Mrs. Bolus added that Mr. Aviles has now been HHC's President for almost eight years, longer than any President in HHC's 43 year history.

Mrs. Bolus called on Mr. Aviles for his remarks.

PRESIDENT'S REMARKS

Mr. Aviles greeted everyone and thanked Mrs. Bolus for her comprehensive report. Mr. Aviles informed the Committee that he would keep his remarks short as there are four CAB reports on the agenda. Mr. Aviles began his remarks by stating that a lot of issues have transpired since the last CRC meeting. He informed those in attendance that he will be on board until the end of March 2013 and that tonight's meeting was his last Community Relations Committee meeting. As such, Mr. Aviles took the opportunity to thank Committee members. He added that Community Advisory Boards have played an important role in the Corporation for decades. Mr. Aviles commented that during his tenure of nine years as HHC President, the relationship between the facilities and the CABs has been a strong one. While there has not been complete and total agreement on all issues, Mr. Aviles praised that one value of the CAB is that it roots HHC to its communities, reflects back to HHC community interests and gives very valuable feedback and input on what and how HHC is doing which often stimulates HHC to think harder about those issues. On the advocacy front, Mr. Aviles expressed his appreciation of what a difference the CABs makes as they spent a lot of time and efforts to advocate on behalf of HHC's interests. Mr. Aviles acknowledged LaRay Brown, Senior Vice President, and her team for their work. In addition, Mr. Aviles complimented the CAB members for their resilience in going to Albany, talking to local, state and federal elected officials and pressing upon the real importance of the services provided by HHC and thereby the importance of continuing to supply the funding HHC rely upon to remain true to its mission during difficult and challenging times. Mr. Aviles added that these challenging times would have been even more difficult if HHC did not have the CABs on its side to advocate on its behalf.

Mr. Aviles continued his remarks and stated that he had worked in the public sector for more than 35 years and at HHC for 17 years. However, Mr. Aviles added that the last nine years of his career as HHC President, had been the thrill of a lifetime. Mr. Aviles noted that HHC is an amazing organization with incredibly dedicated and talented people at every level. Mr. Aviles emphasized that these talented individuals make the Corporation very strong and that it should be noted that over the course of the last 10 or 15 years HHC has been made stronger than ever.

Mr. Aviles stated "that HHC has a national reputation as a public hospital system that provides quality medical care just as voluntary hospitals. Mr. Aviles noted that it is an enormous achievement and a step forward towards equity in health care."

Mr. Aviles concluded his remarks and announced Mayor Bill de Blasio's nomination of Ramanathan Raju, M.D. to succeed him as President of HHC. Mr. Aviles noted that the Mayor's selection of Dr. Raju reflects his strong support to HHC and its mission. Mr. Aviles recalled that Dr. Raju is well known to the HHC Community. He has a very distinguished career as a surgeon and a physician executive. Dr. Raju had worked for many years in the voluntary hospitals sector and in the private practice as a surgeon and, the later years, as a trauma surgeon in Emergency Medicine. In addition Dr. Raju had worked for a number of years at Coney Island Hospital as the first Medical Director and Chief Operating Officer and most recently at Central Office as Corporate Medical Officer elevated to Executive Vice President and Corporate Chief Operating Officer. Mr. Aviles noted that for five years Dr. Raju had been part of the senior team that sets the strategic course for HHC over the years. Since October 2011, for 2 ½ years, Dr. Raju had served as CEO of Cook County Health and Hospitals System, the public healthcare system of Chicago, which has the very same mission as HHC.

Mr. Aviles continued and stated that "Dr. Raju will start his new post on March 31, 2014." Mr. Aviles reiterated that Dr. Raju's credibility, particularly with physicians and nurses, is based upon his own distinguished career as a clinician; and he certainly is someone who absolutely understands the importance of HHC's connection to the communities it serves and the important role of the CABs." Mr. Aviles added that he is hopeful that the CABs would find him an interesting person to work with. Mr. Aviles ended his remarks by thanking the CAB members for being supportive of HHC's agenda and of him over the years.

A standing ovation ensued and Dr. Fred Monderson, Vice Chair, Dr. Susan Smith McKinney Nursing and Rehabilitation Center suggested that Mr. Aviles be one of the recipients for this year's Marjorie Matthews Awards.

Mrs. Bolus acknowledged Dr. Monderson's suggestion and informed him that because the Marjorie Matthews Awards is an appreciation award given to volunteers and not employees the matter would have to go before the Council of CABs to amend the criteria and for a vote.

South Manhattan Network Community Advisory Boards' Reports

Gouverneur Healthcare Services (Gouverneur) Community Advisory Board

Mrs. Bolus introduced Gerald From, Ph.D., Chairperson of the Gouverneur Healthcare Services Community Advisory Board (CAB) and invited him to present the CAB's annual report.

Dr. From began the Gouverneur CAB's report by reminiscing on forty (40) years of community advocacy. Dr. From recalled that the CABs were very different in 1974, he added that CAB members were often hostile, argumentative and aggressive. Dr. From stated that "Gouverneur has since evolved from a forty (40) bed facility to an state-of-the-art Ambulatory Care/Skilled Nursing Facility with 300 beds and over 350,000 ambulatory patients visits a year.

Dr. From continued and informed members of the Committee, CAB Chairpersons and invited guests, that during the course of 2013 a new Executive Director was appointed to Gouverneur Healthcare Services. Dr. From noted that the change in administration did not go over well with the CAB. He stated that "because of the change, Gouverneur had lost support from the community, supporters for annual dinner and staff's moral was down."

Dr. From concluded the Gouverneur CAB's report by highlighting various changes that had occurred over the past year. He noted that Gouverneur Healthcare Services had established a partnership with Rusk Institute, New York University School of Dentistry. Dr. From added that Gouverneur have a new google website that features a virtual tour. He noted that the site had received a 400% increase in viewers. Dr. From ended and stated "that in 2013, and for the first time, Gouverneur staff participated in the China Town parade."

Metropolitan Hospital Center (Metropolitan) Community Advisory Board

Mrs. Bolus introduced Jewel Jones, Chairperson of the Metropolitan Hospital Center's Community Advisory Board (CAB) and invited her to present the CAB's annual report.

Ms. Jones began the Metropolitan CAB's report by thanking members of the Committee for the opportunity to present and acknowledging fellow CAB members who were in attendance to support her.

Ms. Jones presented the members of the Committee, CAB Chairpersons and invited guests with a power point presentation of Metropolitan CAB's annual report.

Ms. Jones reported that the most significant health care concerns and needs for the East Harlem (EH) community is access to medical care. Ms. Jones explained that residents of East Harlem are more likely to lack medical insurance and a primary care physician. Ms. Jones noted that diabetes, obesity, asthma, high blood pressure and hypertension are the most significant health issues in the community.

Ms. Jones continued and added that the most common social concerns facing East Harlem community residents are, crime/violence, drug activity, unemployment, access to healthcare, housing, poverty and education.

Ms. Jones reported that Metropolitan Hospital's facility leadership methods of addressing the community needs is to ensure that MHC provides East Harlem residents and neighboring areas with the most comprehensive medical and behavioral health services available at little or no cost. Ms. Jones noted that the hospital's administration had implemented care teams in Adult Primary Care and embraced the Patient Centered Medical Home model. In addition, the Outreach Department provides free screenings, patient education and links patients to primary care services such as Woman Infant and Children (WIC) program, Managed Care, and the Volunteer Services Department that helped community residents with applications for Medicaid, Medicare and food and nutritional supplement programs.

Ms. Jones informed members of the Committee, CAB Chairpersons and invited guests that Metropolitan's Hospital Center priorities are led by the hospital's determination to become the recognized provider of choice for comprehensive healthcare and supportive services for East Harlem and the surrounding communities. In addition to becoming a leader in offering state-of-the-art primary care services, maintaining status as a high-quality educational site for community-based, culturally-sensitive healthcare and achieving financial viability and long-term stability.

Ms. Jones continued and reported that Metropolitan Hospital Center received 2179 compliments beginning January 1, thru September 30, 2013. The areas identified were: compassionate, respectful, helpful, caring, empathic and being responsive Ms. Jones noted that during that same period there were 148 complaints. The complaints identified included: patient's family member's perception of care, attitude, staff behavior and long waiting times.

Ms. Jones highlighted several of the Met CAB's Standing Committees. Ms. Jones noted that the Program and Planning /Legislative Committee plans, organizes and coordinates all CAB related advocacy activities, including the Legislative Forum and Annual Public Meeting. Ms. Jones added that the Environmental Taskforce was formed to address environmental issues affecting the hospital, the facility's physical plant, and the surrounding areas of the hospital for example the Sanitation Garage and the 2nd Avenue Subway construction.

Ms. Jones reported that Met CAB continues to support the leadership of the hospital in many ways to ensure that the needs of the community are met. Ms. Jones added that the Hospital's Farmers Market was initiated by the CAB several years ago and the Market continues to provide the community, staff and patients with quality fruits, vegetables and healthy eating choices. Ms. Jones also noted that a calendar of events was created and distributed to CAB members for the purpose of keeping them abreast of the hospital's activities and advance meeting notices.

Ms. Jones concluded the Met's CAB report and informed members of the Committee and invited guests that through the CAB's efforts plans are underway for the relocation of the Department of Sanitation Garage located directly across the street from the hospital at 99th St. Ms. Jones explained that the 99th St. project is a new state-of-the art building with a combination of 1 bedroom and studio apartments. Ms. Jones added that HHC will be given priority for individuals discharged from Coler-Goldwater and; the expectation that residents will be linked to supportive services at MHC. In closing Ms. Jones stated "she is confident that the CAB will play an integral role in this project and the Draper Hall Redevelopment project as it progresses.

Mrs. Bolus and Ms. Agnes Abraham commended Ms. Jones on a thoroughly comprehensive and concise report.

Bellevue Hospital Center (Bellevue) Community Advisory Board

Mrs. Bolus introduced Mr. Bobby Lee, Chairperson of the Bellevue Hospital Center Community Advisory Board (CAB) and invited him to present the CAB's annual report.

Mr. Lee began the Bellevue CAB's report by thanking members of the Committee for the opportunity to present and recognizing Bellevue CAB members in attendance.

Mr. Lee acknowledged Bellevue Hospital Center staff for all their hard work during and after Super Storm Sandy. Mr. Lee added that the staff had to evacuate the entire hospital, and that took a tremendous amount of dedication and commitment. He noted that Bellevue Hospital lost power, water, heat and experienced major flood damage in its basements and mechanical spaces. Mr. Lee added that to help minimize flood damage from future storms, the hospital has installed flood barriers at ramps and additional emergency generators are being installed.

Mr. Lee continued and thanked Ms. Lynda Curtis, Senior Vice President, South Manhattan Network, for her leadership over the years. Mr. Lee added that Bellevue is experienced a transition in leadership and the CAB supports the administration.

Mr. Lee informed members of the Committee, CAB Chairpersons and invited guests that William Hicks, Chief Operating Office continues to be extremely supportive of the CAB and had taken the lead to spearheaded changes in the pharmacy. Mr. Lee noted that CAB members participated in Breakthrough which focused on the Pharmacy and the Ambulatory Care Clinics.

Mr. Lee reported that the Bellevue CAB is in opposition of a Sanitation Garage being proposed in close proximity of Bellevue Hospital Center.

Mr. Lee continued and highlighted areas of Bellevue Hospital Center that need improvements: CAB access to patient's survey results; signage in the emergency room; update of all services available at Bellevue and Improved staff interaction with patients.

Mr. Lee concluded the CAB report by stating that the "Bellevue CAB was instrumental with getting local elected officials to prohibit food carts vendors from the entrance of Bellevue Hospital Center." Mr. Lee added that unfortunately the food cart merchants sold affordable meals whereas, Au Bon Pon, the food vendor for Bellevue, prices are not reflected of the patients served by Bellevue.

Coler Specialty Hospital and Skilled Nursing Facility (Coler) Community Advisory Board

Mrs. Bolus introduced Ms. Gladys Dixon, Chairperson of Coler Specialty and Skilled Nursing Facility Community Advisory Board (CAB) and invited her to present the CAB's annual report.

Ms. Dixon began her presentation by acknowledging Ms. Bolus, members of the Community Relations Committee and guests. Ms. Dixon thanked the members of the Committee for the opportunity to share the Coler's CAB 2013 annual report.

Ms. Dixon reported that since the Coler's CAB last report, several residents had been discharged in to the Community. Ms. Dixon added that the discharge of resident had seriously decreased the Board's membership. Ms. Dixon continued and reported that in addition the Facility has undergone changes, challenges and achievements. Ms. Dixon noted that much had been from Hurricane Sandy, installation of windows, sprinkler system, staff adjustments and the relocation of many residents to the Hank J. Carter Rehabilitation Facility.

Ms. Dixon informed members of the Committee, CAB Chairpersons and invited guest that Robert Hughes, Executive Director and the administrative staff provided information pertaining to the Facility's operational initiatives and new healthcare issues at the Coler CAB's monthly meetings. Ms. Dixon added that during 2013, quarterly meetings were held with Mr. Hughes, Administrative Staff and the Goldwater Community Advisory Board.

Ms. Dixon continued and reported that during 2013, members of the CAB's Patient Care Committee expressed their concerns for the residents being discharged from the facility into the Community. She noted that the administration and various departments' heads attended those meetings to address the Committee's concerns.

Ms. Dixon stated that many of the Coler CAB members were disappointed with the cancellation of the Council of Community Advisory Board's Annual Conference. Ms. Dixon added that the annual conference provided CAB members with the opportunity to interact and share ideas with other facilities CABs in addition; important information is provided to expedite the CAB's mission.

Ms. Dixon concluded the Coler CAB's annual report and thanked Robert Hughes, William Jones, Sr. Associate Director/CAB Liaison and Robb Burlage, Ph.D., HHC Intergovernmental Relations staff for their support, dedication and commitment.

Finance Committee – February 11, 2014 **As Reported by Mr. Bernard Rosen**

Senior Vice President's Report

Ms. Marlene Zurack informed the Committee that at next month's meeting a presentation prepared by LaRay Brown, Senior Vice President, Corporate Planning, Intergovernmental Relations and Community Health and the Corporate Planning staff would be presented in response to the Committee's request to address some of the issues raised relative to declining utilization and other factors at HHC in comparison to the healthcare industry. As part of the routine reporting, Ms. Zurack reported that HHC's current cash balance was \$432 million or 27 days of cash on hand (COH) which compares favorably to the FY 14 opening balance of \$323 million or 20 days of COH. The projected year-end balance is expected to be at the same level as the current status. However, that assumption is contingent upon HHC's receipt of \$800 million in UPL payments by June 2014. The receipt of those funds is pending the approval of the methodology by the State and Federal governments. The payment was originally scheduled for January 2014 but was replaced with a DSH payment that HHC received last month. It is important to note that if the \$800 million is not received as planned, HHC will have a major problem. The calculation review by the State and Federal governments

is essential in getting this issue resolved. The reporting of this issue to the Committee is an elevation of the urgency of having this matter resolved by those two entities.

Exchanges Update

Ms. Zurack brought to the attention of the Committee the summary page included in the package for the Exchanges. The data included in the summary highlighted the most current information available to HHC. It is important to note that when Ms. Katz does the reports on the Medicaid eligibility applications processing, getting and reporting the data for the new Medicaid system compared to the old will be very complicated given that the data is very limited at this time. As of February 3, 2014 there were 657,000 applications filed through the NYSDOH portal an increase of 111,541 applications or 20% increase from last month. Based on data through 2/10/14, 696,000 applications were submitted compared to the 657,000, of which 381,000 increasing to 412,000 were enrolled compared to 295,000 last month. The enrollment pace is steadily increasing which is the goal. HHC is working to have its hospital care investigators (HCI) and other staff trained as certified application counselors (CAC) of which 300 staff have been trained against the 450 target by February 28, 2014. The goal is to train 700 staff by March 31, 2014. Based on data reported by HHC facilities, as of 1/26/14 HHC has processed 28,642 applications, 18,500 were Medicaid and the remainder 13,000 were for the Exchanges (QHP).

Ms. Youssouf asked whether MetroPlus would be refunding its members as a result of a glitch in the system that had been reported in the news media.

Mr. John Cuda, Chief Financial Officer, MetroPlus was asked to respond to which he stated that the problem had occurred at Empire and that a deal was made with the State to refund those premiums. For NY, MetroPlus has not had a major issue although there have been some but there are no plans to issue any refunds relative to that problem. MetroPlus sent out letters to some of its members when there was a problem with the issuance of their cards informing them that they were MetroPlus members and that their physicians or provider groups could call MetroPlus customer service to verify their coverage.

Ms. Cohen asked whether HHC has an outreach program for its uninsured patients to assist them in getting enrolled in an insurance plan.

Ms. Zurack stated that there are some efforts; however, the first step in the process as it relates to HHC's revenue is on the inpatient side of applications processing, whereby for those patients who have been admitted an application must be completed immediately. There is a problem in that process in that there have been a number of delays that relate to identity and verification for the homeless and the undocumented. Additionally, the emergency Medicaid process is going through the portal and HHC staff who are required to go through the CAC training have incurred a backlog as a result of having to get that certification. Also there has been a delay by the State in hiring 200 staff to assist with that process. The State has committed to having dedicated staff for HHC when that staff is hired.

Mr. Rosen added that as per Mr. Covino HRA is no longer processing applications for HHC after removing its on-site staff from HHC facilities.

Ms. Zurack explained that HRA had on-site offices at each of HHC's facilities but has since vacated those offices. However, HRA is still processing applications for the non-MAGI population and also for retroactive coverage for individuals who were admitted in prior months. For example, if an application was done in March for a patient who was discharged in February that application would go to HRA. HRA still has a function and there is a learning curve for HHC's staff in terms of where the applications should be sent for processing.

Ms. Andrea Cohen asked if there is a way for HHC to send letters to uninsured patient on the outpatient side who are in the Options program.

Ms. Zurack stated that HHC has done Breaththrough events and have identified a lot of information on that issue. There are reports such as the daily activity report that the facility reviews prior to the patient visit and phone calls are made to patients who are uninsured. Therefore, those patients who are included in the Options program will be informed about the Exchanges.

Ms. Cohen stated that in addition to those efforts what was being proposed was to have HHC use it list of uninsured patients in NYC for outreach purposes that would provide some type of notification from HHC informing them of their options.

Ms. Zurack stated that HHC has done that on numerous occasions.

Mr. Rosen asked if those individuals who signed up used the internet. Ms. Zurack stated that the majority were done by individuals on-line which many have found to be an easier way to sign-up.

The discussion was concluded.

Key Indicators/Cash Receipts & Disbursements Reports

Ms. Krista Olson reported that the total outpatient visits were up by 3.3% or 90,000 visits both the acute and D&TCs are up by the same 3.3%, excluding Coney Island and Bellevue due to the impact of the storm, visits were flat for the acute. The D&TCs, excluding Gouverneur due to the modernization project, visits were down by 2.6%.

Ms. Youssouf asked if there is an explanation for the increase in the visits.

Ms. Olson stated that the increase was due largely to the storm last year. At the D&TCS the increase was due to Gouverneur's completion of its modernization project which is up by 12% and was offsetting the decline in visits at the other D&TCs.

Ms. Youssouf asked if Gouverneur was 100% completed. Mr. Aviles stated that the lobby is the only area yet to be completed.

Ms. Olson added that in the nursing home at Gouverneur the beds are being re-opened. Returning to the report, discharges were up by .3% excluding Bellevue and Coney Island; discharges were down by 5.7%. Nursing home days were down by 16.3% due to the transition that occurred at Coler/Goldwater. Hank J. Carter and Goldwater have been combined on the report.

Ms. Youssouf asked whether the 56.5% decline at Goldwater/HJ Cater is attributable to the move.

Ms. Olson stated that it is related to the move and the decline in beds. The ALOS, there were three facilities above the corporate expected average LOS; Kings Cty at 6/10; Queens and Coney Island both at 5/10 of a day. There were two facilities less than the corporate expected average, Lincoln at 7/10 and Metropolitan 6/10.

Mr. Fred Covino, continuing with the reporting stated that FTEs were up by 54 in comparison to the base period of 6/15/13 through December 2013 which is a small increase that would be discussed in more detail later on the agenda as part of the PS quarterly report. Receipts were \$138 million worse than budget while disbursements were \$29 million over budget for a net total deficit of \$167 million. A comparison of the actuals through December 2013 to the same period last year, total receipts were \$371 million less than last year due to the timing of DSH payments. Last year HHC received \$842 million in DSH compared to \$346 million this FY 14, \$497 million less than last year. However, HHC received \$531 million in DSH receipts in January 2014 which will reduce the variance next month. Expenses were \$32.5 million better due to the timing of City payments. To-date for FY 14, no payments have been made to the City compared to last year of \$141 million was paid to the City during the period. PS expenses are down by \$16 million compared to last year due to a prior year retroactive collective bargaining payments of \$21 million.

Ms. Zurack clarifying that Mr. Covino's reference to the "to-date" was through December 2013 given that there were payments made to the City in January 2014.

Ms. Youssouf asked for clarification of the assumption that the \$33 million is better on a cash basis. Mr. Covino stated that the \$32 million to-date is less than the actual expense last year. Ms. Youssouf asked if it was related to the non-payments to the City, other categories that were underspent; and fringe benefits, etc.

Mr. Covino stated that it was related to all those factors and that the details of that variance would be discussed as part of the PS reporting later on the agenda. Returning to the reporting, PS expenses were less than the prior year. Fringe benefits were up by \$95 million, health insurance also up by \$35 million due to the stabilization payment that HHC made to the City and \$26 million equalization payments. Overall health insurance was up by \$35 million relative to the year over year increase of 5.2%. Additionally pension payments were up by \$35 million and FICA was up by \$20 million compared to last year; whereby HHC received a FICA credit for residents' recovery. OTPS expenses were up by \$59 million due in part to a delay in payments to vendors as a result of HHC's cash balance. However, HHC has since released payments as a result of complaints made by vendors for non-payment. Affiliation expenses were \$9.6 million less than last year due to the physician UPL payment received which offset the overspending. Bond debt was down \$20.8 million due to the debt refinancing. The actuals compared to budget through December 2013, inpatient receipts were down by \$106 million due to a decrease in Medicaid fee-for-service that was down by \$95 million and a decline in workload, 3,000 paid Medicaid discharges, 15,000 paid psych days and 50,000 skilled nursing facility days. Outpatient receipts were down by \$41 million in Medicaid and all other receipts were up by \$8 million. PS expense were up by \$9.6 million and OTPS expenses were \$27 million worse than budget due to the factors previously stated relative to an increase in payments to vendors.

Payor Mix Reports – Inpatient, Adult And Pediatrics As Of 12/2013

Ms. Olson informed the Committee that there were two sets of payor mix reports, the standard quarterly report and a historical payor mix report that was in response to the Committee request. The format of the quarterly report is reflective of the revision in the report that was presented to Committee for the FY 14 1st quarter report. The primary change in the inpatient category, Medicaid total decreased from 61.2% to 59.3% with a decline in Medicaid fee-for-service and Medicaid managed care as well. There was an upward shift in the uninsured from 8.3% to 9.3% which Ms. Katz will discuss in more detail as part of the Medicaid eligibility report that may be related to a delay in the Medicaid applications processing that Ms. Zurack noted in the reporting. Commercial and other are relatively flat and Medicare was slight up. In the adult outpatient, the percentage of total visits for each facility Medicaid is trending downward with a slight decline in Medicaid fee-for-service and Medicaid managed

care. There was a slight increase in Medicare that may be attributable to variation through December 2013. Commercial was also slightly down and the uninsured was slightly up.

Mr. Rosen asked if the data included the emergency room. Ms. Olson replied that the emergency room is excluded.

Mr. Page asked for clarification of the slightly upward or downward trends. Ms. Olson explained that the shift appears to be occurring between the uninsured and Medicaid as opposed to the Medicaid shifting to Medicare or commercial.

Ms. Maxine Katz added that on the inpatient side some of the shifting may be related to timing and the fact that Medicaid decisions are down and are remaining in the uninsured category. Some of it is related to the Exchanges, HRA staff moving out of HHC site locations which has delayed the processing of uninsured cases.

Ms. Zurack added that for background purposes for the new Committee member, some patients come to HHC facilities uninsured and HHC staff processes the Medicaid application on behalf of those patients. There is a lag in the data on the inpatient side, whereby the data was run nine months after the service was rendered and the self-pay count would be higher than six months later given that the patient accounting staff and the HCIs would have processed those uninsured cases for submission to Medicaid. Therefore, the data that is being presented is reflective of the flow of the Medicaid application process.

Committee Member, Mr. Mark Page commented that the delay should be prevalent year-end and year-out. Therefore, when comparing year to year there should not be major shifts.

Ms. Zurack interjected that this year there were extraordinary circumstances because of the shift in HRA to the State and the removal of the HRA staff on-site offices at each of the facilities which is representative of a massive change for HHC in its Medicaid application processing program. Therefore, the data for two-thirds of the FY 14 probably will not be updated until April 2014.

Mr. Page stated that it would appear that HHC is losing money and cases covered by Medicaid due to those noted particular circumstances.

Ms. Zurack stated that HHC is losing total cases and there are fewer people coming to HHC. The data that is being presented by Ms. Olson is based on the percentage changes in the various payors but cautioning not to overreact to the changes on the inpatient side given that it may only be temporary compared to the outpatient side where there are no processing issues.

Ms. Youssouf added that perhaps the Medicaid issue on the outpatient side may be covered in the presentation that will be presented next month to the Committee.

Mrs. Bolus asked if Options are half and half. Ms. Katz stated that the Options data is comprised of the uninsured patients who have been fee-scaled by HHC only.

Ms. Olson continuing with the reporting stated that the pediatrics outpatient excluding the emergency room as well there was a slight upward shift in Medicaid due to an increase Medicaid managed care; a slight decline in both the commercial and the uninsured. That level of variation may be due to the time period.

Ms. Youssouf asked if the pediatrics data was included in the adult outpatient payor mix.

Ms. Olson stated that the inpatient is combined but pediatrics makes up a small percentage of the overall inpatient. On the outpatient side the adult and pediatrics are separate give that there is a different process for determining eligibility for children compared to the adults.

Ms. Youssouf asked of the two, pediatrics and adult which is the largest.

Ms. Olson stated that the adult visits volume is probably larger but would need to be confirmed. However, the percentage of Medicaid pediatrics is at 80% compared to the adult at 40% due to the difference in the eligibility requirements which is the reason for the separation of the services as opposed to combining the two which would show completely different outcomes.

Ms. Youssouf added that overall the reporting was fine but that the question was to get a better understanding of whether it was more for one than the other and the difference between the two reports.

Historical Payor Mix Reports

Ms. Olson moving to the historical payor mix reports stated that corporate-wide the share of discharges that are Medicaid increased slightly but remained relatively flat during the four year period.

Mr. Rosen asked if the reports were reflective of the same period as the payor mix reports. Ms. Olson responded that the historical data is based on year-end data for all of the FYs by payor mix.

Ms. Zurack added that it is service through June 30th run in August of each year.

Ms. Olson continuing with the reporting stated that the transitioning from Medicaid fee-for-service to Medicaid managed care was approximately 7%. Medicare discharges increased slightly during the period and Medicare fee-for-service declined slightly by .2% compared to an increase of 1% in the Medicare managed care plans. The commercial discharges remained flat and other decreased slightly by .6%. The uninsured decreased slightly by .5% primarily in the non-HHC Options category. Overall within the facilities there were some wider swings and difference between facilities. Bellevue for instance had a lower share of Medicaid primarily due to a higher share of the other categories due to the facility's prisoners' population.

Ms. Youssouf asked if the total data was year to year through 2013. Ms. Olson stated that the data was not re-run but rather the same data that was reported to the Committee for the years indicated. If the data had been rerun as previously mentioned some of the self-pays would have moved to Medicaid.

Ms. Cohen asked if there is a breakout of what portion of those were Medicaid managed care, MetroPlus, HealthFirst, etc. and those that were capitated.

Ms. Zurack stated that the largest plan is HealthFirst for Medicare and MetroPlus is the largest for Medicaid.

Ms. Cohen asked what portion of the plans' payments in the discharges is from a capitated payment, capitation versus fee-for-service.

Ms. Zurack stated that in order to respond to those questions a review of the data would be required; however, HealthFirst is the predominant plan for Medicare.

Ms. Cohen asked if there was data for the capitation in relation to the plans, fee-for-service versus capitation.

Mrs. Bolus asked if HealthFirst was a good investment for HHC.

Ms. Zurack stated that the value of HHC's investment was substantial relative to Elmhurst hospital's original investment but the data can be run to see the actual value of the investment. HHC has received distributions year over year from the HealthFirst investment and HHC has an investment of 7% ownership of that company.

Mr. Rosen as a follow-up asked if Ms. Cohen's questions were answered.

Mr. Aviles in response stated that Ms. Cohen questions related to the percentage of the revenue that is capitated based on the various managed care plans. On the managed care side HHC is past the 5% mark in terms of capitation per plans; however, there is a large amount of emergency Medicaid which continues to be fee-for-service. Therefore in total revenue as HHC is approaching 50%, HHC has not yet crossed that threshold in term of capitated compared to fee-for-service.

Ms. Zurack added that in response Ms. Cohen's request, next month that data will be shared with the Committee the percentages from the various managed care plans for Medicaid and Medicare revenues versus others. However, it is not certain that it would address the question but would be a start in getting to the answer.

Ms. Olson returning to the reporting stated that the adult outpatient payor mix unlike the inpatient, the adult visits shifted downward in Medicaid fee-for-service and managed care due to an increase in self pay visits. Medicare visits increased slightly which could be attributable to a change in the eligibility requirements and a change in the data base.

Ms. Youssouf stated that the self-pay population was always large but in 2010 there was a significant increase therefore the trend in the data was not clear in that the data appeared to be counterintuitive.

Mr. Rosen added that in confirming with Mr. Aviles the undocumented can get outpatient Medicaid and that when there is a change in the data there is likely to be some major shifts in the data.

Ms. Olson stated that in the outpatient pediatrics there was a slight increase in the Medicaid versus the managed care; a light increase in the uninsured and a slight decline in the Child Health Plus (CHP) percentage.

Mr. Page stated that one of the problems is getting the information and the way in which it is presented so that it is comprehensible. The percentages are a very simplified version of what has taken place; however, the total number of cases is not available.

Ms. Olson stated that this was the first time for this type of report.

Mr. Page added that the data would be available given that the percentages are driven by the data. Ms. Zurack stated that the raw data was reported in the past and was switched to the current format.

Ms. Page stated it was understandable in terms of the change but if possible the raw data should be included, perhaps on the back of each of the reports which would provide what the actual size of the base and the distribution of the base.

Ms. Olson explained that in the past the Key Indicators report did not include the outpatient visits but now that it is included the intent is to focus the payor mix reports on the payors specifically the shifts in the various payors.

Mr. Page stated that the issue was not related to that given that the reporting is sufficient in term of the percentage but that the request is simply to have the raw data also included so that it is comprehensible.

Ms. Zurack in response stated that the raw data would be provided. The reporting was concluded.

Medicaid Inpatient Processing Report

Ms. Katz before getting into the reporting informed the Committee that the report would be changing due to issues reported by Ms. Zurack and Ms. Olson that relate to the implementation of the Exchanges. The reports data was through December 2013; however, as of January 2014 the source of that data that has come from HRA and other systems is no longer available but now must be obtained from HHC facilities' dashboards. Going forward, the data will be reported to the Committee in a revised format that captures the processing for the Exchanges. The other important point is that last year, HRA removed its inpatient staff out of HHC facilities and for a short period of time created a backlog in the actual eligibility decisions. HRA has been extremely cooperative with HHC in resolving the backlog. The outcome of those efforts is not reflected in the data that is being reported but will be reflective in the data in the coming months. In terms of data in comparing 2013 and 2012, there is a decrease in the submissions and decisions from HRA. The largest decrease was in the submissions during the second quarter of FY 14, primarily in November 2013 which was due in part to the holidays during the month and the removal of the HRA staff out of the facilities. The percentage of decisions to the submissions also decreased due in part to the Exchanges and HHC staff getting familiar with the new process.

Mr. Rosen asked if the format would change. Ms. Katz replied that it would and will include the MAGI and non-MAGI and the OHPs.

Ms. Zurack explained that in the old Medicaid processing system with HRA, there was an automated reporting but there were some limitation as reflected in the reporting to the Committee on the data that did not match due to the lag. However, with the new system the data that is going through the Exchanges, to-date HHC does not have an automated reporting to capture and report that data. Therefore, the data must be compiled by the facilities from the staff's reports.

Mrs. Bolus asked how long will it take for that type of system to become available for HHC. Ms. Zurack stated that it could take up a year given that the State has to hire the staff and the get the Exchanges working.

Ms. Youssouf asked if there are overall statistics available from the State. Ms. Zurack stated that there are statistics; in fact the source of the data that have been reported to the Committee has come from the State's website. HHC can download a report for each of its CACs and there is a customer's support system that is yet to be sufficiently staffed that is available to assist in the process.

Ms. Youssouf asked if HHC's CACs are required to keep a log of all their processing efforts. Ms. Zurack stated that it is available through the portal by each CAC, but the data has to be aggregated by the facilities and corporate-wide which is a very time consuming process at this time.

Ms. Cohen asked if the basic issues relative to the Medicaid application submissions and decisions through December 2013 and the declines are due primarily to data issues or one-time changes or actual declines.

Ms. Katz stated that some of it may be due to an actual decline in submissions but it is yet to be determined and the impact of that change.

Ms. Zurack stated that the decline is related to a number of issues, the removal of the HRA staff from the facilities; the training of HHC staff on the new system and certification of the staff to CACs which has created a backlog. The time that HRA takes to process HHC applications has increased but it expected that this will be resolved as the process moves forward.

Mr. Page added that it would appear that the question being asked relates primarily to the size of HHC's overall business in Medicaid, Medicare, Managed Care, etc. The exactness of the information that is being derived makes it somewhat unbalanced in terms of the other factors that causes it to fluctuate and is obscuring the answer to the basic question that relates to the volume of business by facility and corporate-wide. That being said, perhaps consideration should be given to changing the frequency in reporting the data that might alleviate some of the abnormalities in the data so that the trends would be more identifiable and less skeptical as the issues are repeatedly defined. Based on the discussions it would appear that the period is not the problem but rather collecting the data.

Ms. Katz agreed adding that unlike the payor mix reports which at any time it can be determined the percentage of the overall cases relative to each payor but the eligibility data is related to productivity. Patients come to HHC facilities as uninsured and the applications are processed by the staff for submission to HRA for processing and approval.

Ms. Zurack added that the Medicaid eligibility reporting is not related to HHC's revenue as opposed to the budget reports that are more specific to revenues and expenses. The eligibility reports were developed to provide the facilities with an incentive to get individuals to qualify for Medicaid. In prior years there was a target for each of the facilities but was eliminated. Based on the current eligibility processing through the Exchanges there is a need to change the reporting formatting.

Mr. Page stated that the issues that were reiterated throughout the reporting were fully understood as well as the reports that relate to HHC's cash. However, the payor mix reports are based on the percentage of cases which as previously stated and requested; the raw data is needed so that the reporting is comprehensible.

Ms. Youssouf added that perhaps a portion of a response to some of the questions raised maybe related to the utilization that may get addressed in next month's presentation to the Committee.

Mr. Page stated that it is a basic question, "how's business." Ms. Zurack in response stated that business is down, expenses have not decreased at the level as the decrease in revenue and more patients are uninsured.

Ms. LaRay Brown stated that the presentation will not answer all of the questions but will go a long way toward answering some of the things that have been discussed.

Ms. Youssouf added that although the Committee may not get all of the answers to the questions it would be data that HHC can continue to expand to which Ms. Brown added that it will be a foundation.

The discussion was concluded and the next information item was introduced by Mr. Rosen.

PS Quarterly Key Indicators Report – 2nd Quarter

Mr. Covino stated PS disbursement actuals against the budget bottom-line, expense were \$9.6 million over budget due to the carrying cost of those employees at Coler/Goldwater who were not transferred out and were not budgeted. There were 232 employees transferred to other facilities and absorbed into the facilities budgets.

Ms. Youssouf asked if HHC absorbed all of the staff. Mr. Covino responded that there were no layoffs.

Mr. Rosen asked if the overspending was due primarily to Coler/Goldwater.

Ms. Youssouf asked if in the budget the assumption was that those employees would not be off the payroll. Mr. Covino stated that the budget did include that assumption.

Ms. Youssouf stated that it did not appear that the budget included those employees remaining on payroll given that if that had been the case then the variance would not be as significant as stated.

Mr. Covino stated that the only place there was a deviation was at HJ Cater/Goldwater given that there was no contingency budgeted for those staff to remain on payroll.

Ms. Zurack added that the budget is a plan and as such was reflective of the plan to have those employees off the payroll. Therefore, the budget did not include any provision for having that staff remain on payroll beyond the plan.

Mr. Covino added that it was budgeted that way to show the required reduction.

Ms. Youssouf in an effort to understand what had been reported stated that in actuality there must have been some indication where the staff would go; therefore bottom-line there should not have been an overage if those employees were included in the budget as transfers to other facilities into budgeted vacancies.

Mr. Covino attempting to explain stated that the plan included a reduction over a period of time and the plan was not finalized at the time those employees were still on payroll.

Ms. Youssouf stated that based on what was said the plan/budget assumed that those employees would be off the payroll.

Ms. Covino stated that was not the plan but rather those employees would go into vacancies at other facilities. The plan includes an increase of 250 employees not related to the reassignment of those employees.

Mr. Page added that it appeared that based on the explanations given the vacant slots at other facilities were used to move that staff into and that the \$9.5 million is the delay in identifying the vacant slots or even the slots becoming vacant. Consequently, the vacant positions were not available at the time they were expected when the last patient left Goldwater.

Both Ms. Zurack and Mr. Covino agreed that it was exactly as Mr. Page had stated.

Mr. Alan Aviles added that the reason for the increase in staff is related to funded programs through grants and or State and Federal funded programs for specific initiatives such as the Patient Centered Medical Home (PCMH). In order to comply with the certification of the PCMH initiative, the hours of operations were extended which requires additional staff. Additionally, the implementation of the electronic medical record (EMR) also requires additional IT personnel.

Ms. Youssouf stated that it is somewhat confusing in that it was reported earlier that staffing increased by 54 FTEs that does not appear to be related to the staff that was transferred from Goldwater.

Ms. Zurack stated that the 54 FTEs were not against the budget but rather against the base period of June 15, 2013 which at that time there were some vacancies. The actual reporting is against the actual base. HHC ended last year under its FTE target by 700 and to get back up to budget the plan includes an increase in FTES of 250.

Mr. Covino getting back to finalizing the reporting stated that the increase in staffing was in nursing, managers and residents. Mr. Aviles added that the increase in managers was due to the IT staff hired to meet the competitive market.

Mr. Covino stated that the overtime budget versus actuals was up by \$3.3 million against the budget. There were some improvements since the last reporting in September 2013 and in January 2014 the increase has lessened. Overtime compared to year over year increased by \$3.8 million of which 3.3% was in nursing; 13.7% in plant maintenance; and 3.4% in all other. The plant maintenance overtime is being addressed by JCI and is expected to decrease in the months ahead. Nurse registry increased due to the timing of payments of \$5.8 million of which \$4 million was due to payments on behalf of prior months. Allowances were up by 5.8% due to the replacement of temporary employees. The reporting was concluded.

Medical & Professional Affairs / Information Technology Committee **February 13, 2014 – As reported by Mr. Alan Aviles**

Chief Medical Officer Report

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

Overdose Prevention

Phillip Seymour Hoffman's death has brought increased public attention to the use of overdose prevention kits that include the administration of naloxone, an opioid antidote. Research suggests that up to 85% of users overdose in the presence of others so the distribution of overdose prevention kits can save lives. About 18 months ago, HHC has developed policies and procedures for distribution in licensed OASAS programs, Inpatient Detox and Clinics that followed state and city requirements. The kits are free and distributed by DOHMH. HHC currently has four facilities distributing kits: Kings County, Queens, Jacobi, and Bellevue, and is ramping up for corporate-wide distribution. The original legislation was created to distribute kits directly to patients by trained providers. NYS has pending legislation which will expand the ability of kits to be distributed to family, friends and organizations to have a much broader distribution while keeping training and reporting requirements. HHC continues to work to expand our ability to distribute the kits to heroin users and expand beyond behavioral health programs to include emergency departments and primary care.

Accountable Care Organization Updates

The 2013 ACO Quality Reporting Period is underway, with coordinated leadership efforts underway with IT and each facility's Quality Management teams. Working to validate automated measures developed by IT with vendor and QM leads. ACO team is hosting weekly support webinars and site visits for chart reviewers. Initial Claims Data Analysis reveals population of 115 patients (1%) responsible for 18% of 2013 spending. Hotspot analysis is being conducted with facilities to develop narrative understanding of this group. ACO Leads are designated at all 17 facilities, with Leadership Retreat to take place this month. The ACO team has conducted 14 facility kickoff presentations, as well as launched a series of Provider Education Webinars. The ACO team is working with PCMH to integrate ACO data into standard clinical workflows. Siemens analysts have created mock-up of ACO Point-of-Care Notification field under the direction of the ACO. There is ongoing development and testing of QuadraMed modifications for ACO performance in collaboration with IT.

Influenza Vaccination

Currently 83% of our employees are vaccinated (approximately 31,000 employees). Some of our facilities have 90 – 92% vaccinated rates. Approximately 20,000 contractors, volunteers, vendors, etc. were also vaccinated. This is considerable progress from previous years.

MetroPlus Health Plan

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 30, 2014 was 433,300. Breakdown of the plan enrollment by line of business is as follows:

Medicaid	362,516
Child Health Plus	11,678
Family Health Plus	26,430
MetroPlus Gold	3,501
Partnership in Care (HIV/SNP)	5,312
Medicare	7,860
MLTC	465
QHP	15,210
SHOP	328

The QHP numbers have increased to over 15,210 since January 1st, 2014 because we have allowed members to pay through January 24th, 2014. In addition, we still have over 10,000 additional applicants who have not yet paid for their coverage.

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. On a positive note, the losses to Healthfirst and Fidelis were 30% lower this month.

MetroPlus membership has increased since my last report to this committee. We gained over 15,000 Exchange members in January, with the implementation of our Qualified Health Plan offerings on the New York State of Health (NYSoH).

MetroPlus ended 2013 with our membership at 421,000 members. This reflects a 4.5% decrease in membership over the year. As I have discussed throughout 2013, factors contributing to the decrease include eligibility correction due to Third Party Health Insurance, failure of members to recertify, losses to competitor health plans and delays in processing applications through HRA.

In regards to the New York State of Health (NYSoH), as of January 31st, over 380,000 New Yorkers enrolled in the NYSoH. As of January 30th, 2014, MetroPlus has received over 26,000 completed applications and have over 15,000 paid members. We have also received our files with Medicaid and Child Health Plus enrollments, and we have approximately 4,900 new Medicaid and Child Health Plus members who have enrolled through the Exchange website. We have identified that there is a lag in the time from when a consumer completes an application to when they are enrolled in a health plan. Given this delay, as well as continued consumer interest, we anticipate a continued increase in membership until the open enrollment period ends on March 31st, 2014.

The Department of Financial Services (DFS) presented health plan representatives with a timeline for 2015 forms and rate submissions for our marketplace products. DFS and NYSoH staff indicated that invitations for plans to participate in the marketplace will be issued in early-March, with plan responses due back a month after the release.

This month, MetroPlus received a notice from the NYSDOH of its intent to begin on-site focus surveys of our plan compliance with the Fraud and Abuse Program Integrity requirements. This is a result of the findings of an audit of the New York State Department of Health's oversight of these requirements by CMS. The first component of the survey is a review of certain documents that are to be submitted no later than February 11, 2014. The second component of the survey is an on-site review of the Plan's Fraud and Abuse Program, as well as compliance with Medicaid Program Integrity requirements. During the on-site component, the team will meet with key staff who are responsible for the Plan's Fraud and Abuse Program and Medicaid Integrity Compliance Program, including the Plan's Fraud and Abuse Director (and/or compliance officer), Medical Director or Director of Credentialing, and staff responsible for fraud and abuse and compliance training for all Plan employees. Our Compliance area is currently compiling all of the documentation that will be needed for the onsite visits as well as ensuring that pertinent MetroPlus staff is ready for their respective interviews. We expect the DOH to be onsite on March 25th, 2014.

After months of preparation to join the Fully Integrated Duals Advantage (FIDA) program, MetroPlus has completed our on-site FIDA readiness review. Reviewers from NYS and CMS conducted their review beginning on January 14th, 2014 and ended the following day. The site visit was an overall success, and the verbal feedback provided by the reviewers has been taken into consideration as we continue to push towards an October 1st, 2014 deadline.

Finally, as I have been reporting to this committee, MetroPlus had been preparing for the carve-in of the nursing home population beginning January 1st, 2014. This carve-in has been delayed until March 1st, 2014, pending CMS approval.

Chief Information Officer Report

Bert Robles, Senior Vice President, Information Systems

Mr. Robles provided the Committee with the following updates:

Meaningful Use (MU) Stage 2 Update:

As reported here last month, once QuadraMed announced the general availability of QCPR Release 6.0, HHC would quickly move forward with this upgrade with the goal of completing this upgrade implementation across HHC by the end of February 2014.

The North Bronx Healthcare Network's QuadraMed version 6.0 went live on January 10th after a demanding seven (7) months' worth of regression testing, validation and configuration of this new functionality. Harlem and Kings County Hospital Centers immediately followed as early adopters on January 24th and February 2nd respectively. The remaining seven (7) HHC hospitals are scheduled to go live by the end of this month.

This upgrade to version 6.0 is an important step towards HHC achieving Meaningful Use (MU) Stage 2. The attestation period is still planned for the third quarter of Federal Fiscal Year 2014.

Of the nineteen (19) MU objectives, Medication Reconciliation, patient access (portal) and transition of care (summary of care) remain at risk as they require extensive user training, patient engagement and involved technical integration with external sources. Equally challenging are the higher thresholds set for each objective. Barcoding Medication Administration (BCMA), also complex, is now complete.

The ongoing activities for this month include preparation and planning for QCPR 6.0 go-lives for the remaining hospitals, monitor and manage progress of work accomplished, continued collaboration with business and vendors, data validation and the initiation of security risk assessment.

Patient Portal Update:

To meet Meaningful Use (MU) Stage 2, a patient portal is required to address Measure 6 which provides patients with electronic access to their visit summary after discharge. The decision was made to leverage the patient portal that is part of the Care Plan Management System (CPMS) deployed last year to our care coordinators.

The patient portal is currently ready but deployment is dependent on the upgrade of QuadraMed to version 6.0 and the interfacing of QCPR with the portal which is currently underway. In QuadraMed, our clinicians will create the visit summary as part of the discharge process. The visit summary is formatted as a CCD (continuity of care) document and transmitted to the portal, where a patient can then view the information online. Training materials are in place for the portal.

QCPR version 6.0 is being rolled out across all facilities and should be complete by the end of this month. Testing of the integration with the Portal will follow.

Action Items:

Three Resolutions were brought to the Committee, they are as follows:

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to purchase computer workstations, laptops, and IT peripherals for the entire Corporation through Third Party Contract(s) from various vendors on an on-going basis in an amount not to exceed \$7,200,000, over a 12 month period, which includes a 10% contingency of \$654,545.50.

This resolution was approved for consideration by the full Board of Directors

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to purchase storage hardware, software, and associated maintenance from various vendors on an on-going basis via Third Party Contract(s) in an amount not to exceed \$7,200,000 for a one year period, which includes a 10% contingency of \$654,545.50.

This resolution was approved for consideration by the full Board of Directors.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to purchase networking hardware, software and related consulting and technical services through various vendors via Third party contracts on an on-going basis in an amount not to exceed \$28,300,000 in capital funds for a networking infrastructure refresh program over a two year period.

This resolution was approved for consideration by the full Board of Directors.

Information Items:

Chronic Illness Control in the HHC PCMH

Dr. David Stevens gave an overview of the barriers to Chronic Illness Control, recognition of uncontrolled illness, effective treatment plans, self-management support, as well as patient-centered access for maintaining control.

Behavioral Health Update

Ms. Joyce Wale and Dr. Gary Belkin presented an overview of the behavioral health environment, the HHC transformational activities, utilization data (HHC ALOS, 30 day Readmission Rate within HHC, use of seclusion, physical restraint, assaults and fights, rate of inpatient psych IM medication use, continuity of care and detox aftercare met), as well as some of the challenges and uncertainties in the behavioral health field.

Strategic Planning Committee – February 11, 2014

As reported by Josephine Bolus, RN

SENIOR VICE PRESIDENT REMARKS

Ms. Brown greeted and informed the Committee that her remarks would include a brief update on federal, state and city issues.

Federal Update

Two Midnight Rule

Ms. Brown stated that the “two-midnight” rule was promulgated by the Centers for Medicare and Medicaid Services (CMS). She explained that essentially the rule required hospital providers to determine the medical necessity of an inpatient stay within a very restricted time frame. The rule stipulates that, if the duration of a patient’s visit does not cover two midnights for the purpose of evaluation and/or observation that stay would not count as an inpatient stay. Ms. Brown stated that this rule had created a great deal of anxiety on the part of hospitals as well as hospital-based physicians because the rule arbitrarily uses two midnights to determine when an inpatient admission would be justified and it failed to address the provider community’s concern with developing a new payment policy for short inpatient high acuity stays. Furthermore, there is no guarantee that the issue will be addressed in the proposed inpatient payment rule this April.

Ms. Brown informed the Committee that there was significant provider level advocacy concerning the “two midnight rule. This new rule, if implemented, could cost HHC from \$23 - \$28 million per year. In response to advocacy from hospital groups, physicians and others, on January 31, 2014, CMS announced a six month delay until September 2014 of the enforcement of the “two-midnight” rule. Ms. Brown further explained that, during the delay period, CMS contractors would continue to carry out probe and educate prepayment reviews on a sample of inpatient claims with dates of admission from October 1, 2013 through March 31, 2014. The probe and educate reviews are intended to determine if hospital inpatient claims comply with the new rule. Those that fail to comply with the new benchmark requirements will be denied. Contractors also will continue to carry out educational outreach to providers.

Mrs. Bolus, Committee Chairperson, asked if the diagnostic related groups (DRGs) would have any effect on the “two-midnight” rule. Ms. Brown responded that these were two separate issues. Mrs. Bolus asked if staff within the observation units would have a problem with the rule. Ms. Brown clarified that the major concern was that CMS had created a fixed rule that was based on how long a patient stayed in a particular setting, which defined or determined whether the person during that period of time would receive inpatient services and resources or not. Ms. Brown explained that, through this rule, CMS is saying that any stay less than two midnights would be classified as outpatient services, which would generate a lower reimbursement rate.

Ms. Brown provided a brief update on the implementation of the Affordable Care Act. She stated that the Administration granted another extension to business groups. Specifically, companies with workforce from 50-99 employees were given an additional year through January 1, 2016, to comply with the coverage mandate. For businesses with 100 or more employees, their deadline will continue to be January 2015. Ms. Brown added that were newly released technical provisions concerning the calculation of work hours, full time versus part time, which may also provide some relief for those companies. Ms. Brown commented that one entity’s relief may become another entity’s problem. Workers in companies with less than 100 employees will have to wait another year before they have the opportunity to obtain coverage through their employer. On the other hand, some workers in companies with 100 or more employees may not have the opportunity to gain employer based coverage as a result of the new formula for calculating work hours. Ms. Brown commented that, this was a political maneuver on the part of the Administration as they have been criticized via headlines of recent news articles that stated, “Obamacare means losses of jobs.”

World Trade Center Environmental Health Center Program Update

Ms. Brown informed the Committee that the World Trade Center Environmental Health Center (WTC EHC) had received a positive written evaluation of its 2013 performance under the World Trade Center Healthcare Program’s Clinical Centers of Excellence (CCE) contract. Ms. Brown added that this positive evaluation had been reinforced by a positive site visit this past week from the CCE’s Program Officer who had

also congratulated the WTC EHC for meeting all required deadlines throughout 2013 for submissions of numerous routine reports. Ms. Brown reminded the Committee that the WTC EHC is an important program for community residents, workers, passersby and students of the areas that had been affected by the destruction of the World Trade Center. She also reminded the Committee that WTC EHC services are provided at three HHC facilities including Bellevue and Elmhurst Hospitals and Gouverneur Diagnostic and Treatment Center. Ms. Brown clarified that this program is a new federal program which is different from the first responders program with the Fire Department and Mount Sinai's programs. Ms. Brown noted that the reporting and documentation requirements, as designed by the federal government were very strict and that there was a great deal of interaction about what can or cannot be provided. Ms. Brown thanked HHC's General Counsel, Mr. Salvatore Russo, Mr. Wayne McNulty, the Corporate Compliance Officer and Ms. Marlene Zurack and, in particular, Ms. Maxine Katz in HHC's Finance Division for their assistance with securing this positive evaluation. She stated that, "it takes a village."

City Update

Ms. Brown reported that the City Council Health Committee had scheduled a hearing on February 24, 2013, to review HHC's restructuring plan. Ms. Brown noted that this hearing would be the first hearing led by the new Committee Chair, Corey Johnson. In addition to learning about what progress HHC has made on its objectives, Ms. Brown commented that, it was expected that Council would also be interested in learning about how these initiatives have affected both staff and patients.

Information Item:

2014-2015 State Fiscal Year Executive Budget Overview

Wendy Saunders, Assistant Vice President, Office of Intergovernmental Relations

Ms. Saunders greeted Committee members and invited guests. She began her presentation by stating that, two weeks ago, Governor Cuomo had released his Executive Budget for SFY 2014-2015 which would begin on April 1, 2014. Ms. Saunders reported that the \$137.2 billion budget would increase overall spending by 1.7%; and projected a \$2 billion surplus by SFY 2017-18, which would result from a two percent reduction in spending over that time period. She added that a big part of the Governor's package this year focused on a \$489 million tax cut package and an increase in education spending.

Ms. Saunders reported that, in the area of Medicaid spending, there is a proposal to increase Medicaid total spending by 3.8% for a total of \$58.2 billion. Ms. Saunders explained that this increase equated to \$604 million more spending over last year's budget. She explained that Medicaid increases were calculated based on the work of the Medicaid Redesign Team (MRT) and based on the 10 year rolling average of the medical component of the consumer price index (CPI). In addition, this year's budget represents the second year of a 2-year agreement on Medicaid spending that was enacted last year. Ms. Saunders cautioned that the increase in Medicaid spending does not mean an increase to providers. This increase will cover enrollment expansion, increases in patient acuity and increase in the total number of Medicaid patients that are currently enrolled in the state. Along with the increase in Medicaid spending, there is a proposal to extend the global Medicaid cap for one year. Ms. Saunders explained that, along with the global Medicaid cap, the Commissioner of the State Department of Health (SDOH) was granted "superpowers" to make cuts to providers and to plans to ensure that Medicaid spending remained under the cap. Ms. Saunders explained that, if spending exceeded the cap, the Commissioner of Health had the ability to administratively cut providers' rates.

Ms. Andy Cohen referred to the childless adult population and noted that there had been a significant change in the way that Medicaid would be funded for that population. Ms. Cohen asked, since the cost to the state for caring for that population had been significantly reduced, how this change is reflected in the Global Cap. Ms. Saunders responded that, last year, there was a projection of a very significant increase in federal funding for this budget year and that projection was revised downward. In addition, fiscal relief is included in the Medicaid budget. Ms. Saunders further explained that there was roughly \$300 million that was proposed in the budget as state fiscal relief. She explained that elsewhere in the State budget attempts were being made to keep this amount in the healthcare section and to spend it by addressing the Office of People with Developmental Disabilities (OPWDD) pay back to the federal government. Ms. Saunders added that \$300 million would be shifted from Medicaid to pay for that outside of the Global Cap. Ms. Saunders noted that this would be possible due to the availability of ACA funding and because Medicaid spending had been less than what had been budgeted.

Ms. Cohen commented that the two big items that the fiscal relief amount would be spent on are the OPWDD pay back and the county caps. Ms. Saunders explained that two years ago, the state had capped the amount of increase that any county or locality could be expected to pay from their portion of the Medicaid budget. She reminded the Committee that Medicaid funding is comprised of the federal and the non-federal share which is split between the state and the localities. She commented that states spend more on Medicaid.

Ms. Cohen referred back to Ms. Saunders' statement about last year's projection of the federal portion of Medicaid funding. She asked how much of the savings had been revised downward. Ms. Saunders answered that she could not recall the exact number. However, Ms. Saunders stated that, while it was originally anticipated that would be 100,000 single childless adults, the actual number was closer to 70,000 or 79,000 of the newly first time eligible.

Ms. Saunders reported that the Global Cap had been extended for another year and would remain in place until March 31, 2016. She added that included in this year's budget were two years' worth of spending agreed to by the Legislature, which helped to stabilize the funding.

Ms. Saunders reminded the Committee that the Governor had proposed to restore the two percent across the board rate cut which was implemented in his first year in office as part of the MRT recommendations. She added that the total value of the two percent is \$17.6 million for HHC and some additional funds for MetroPlus. Ms. Saunders stated that SDOH had been given the authority to restore those funds which were already included in HHC's financial plan.

Ms. Saunders reminded the Committee that there would not be any inflationary increase or trend factor for Medicaid providers this year. She stated that, as part of last year's budget, the inflationary rate had been frozen. However, if HHC were to have received a trend factor, the impact to HHC would have been \$26.4 million.

Ms. Saunders reported that there was a positive new budget proposal related to the Global Cap called the "shared savings" plan. She explained that under the "shared savings" plan, each year (before January) the SDOH would calculate actual spending under that Medicaid Global Cap amount. If spending is less than projected, the delta, or savings, will be given back to healthcare providers and health plans in two parts:

- At least 50% of any shared savings would be distributed proportionately to all providers and plans (based on Medicaid claims in the previous 3 years), and
- No more than 50% would go to "financially distressed and critically needed providers" as determined by SDOH.

Ms. Saunders reported on the capital funding proposal that was included in the budget. She stated that a positive new development was a proposal for a \$1.2 billion capital program over seven years. This program will put out \$200 million a year in the first five years and \$100 million for the last two years. Hospitals, nursing homes, diagnostic and treatment centers, and licensed clinics are all eligible to get this funding for closures, mergers, restructuring, infrastructure improvements, primary care capacity expansion, promoting integrated healthcare delivery systems and providing continued access to essential health services. Ms. Saunders noted that the program was meant to compliment the proposed Medicaid Redesign Team (MRT) 1115 Waiver that the state was negotiating with the federal government. Ms. Saunders also noted that the funding would be distributed at the discretion of the State Health Commissioner. Applicants will not be required to go through a competitive process where the applicants with the highest scores get the funding. However, providers who are eligible for funding under the proposed Waiver would be given preference for these funds.

Ms. Saunders reported on the Regional Health Improvement Collaboratives (RICs) that were proposed in the budget. Ms. Saunders informed the Committee that the federal government had determined that the RICs would not be eligible for waiver funding. She reported that \$7 million would be allocated to establish 11 RICs. Ms. Saunders noted that the RICs would be modeled on the Finger Lakes Health Systems agency. Their purpose would be to convene healthcare stakeholders to identify challenges, then recommend and implement solutions. Ms. Saunders stated that, while RICs' main goal was to achieve savings across the health care system through collaboration and restructuring, the major RICs activities will be the following:

- Assuring high-quality accessible primary care;
- Providing technical assistance for financial and business planning to encourage the development of integrated health care delivery systems; and
- Providing assistance to primary care providers for adopting and using electronic health records.

Mr. Robert Nolan, Board Member, asked if New York City would be considered a RIC. Ms. Saunders responded that New York City would be its own RIC. Long Island would have one and Rochester its own. Mr. Bernard Rosen, Board Member, asked if RICs have sought capital funding. Ms. Saunders responded that later in her presentation, she will discuss the Vital Access Program, under which, HHC has received \$5 million in addition to funding through the HEAL NY program. Ms. Brown added that the \$1.2 billion is another iteration of the HEAL-NY program which was mostly capital dollars that HHC received. She informed the Committee that there was a lot of HEAL NY funding across the system. Ms. Brown reported that the most recent HEAL NY funding had been for the Vital Access Program which, in last year's budget, included both service and capital. She added that the \$1.2 billion was basically an extrapolation of what had been originally included in the \$10 billion Medicaid Waiver. Ms. Brown explained that there had been robust discussions with the federal government on this issue. They will not fund capital principally based on their experience with HEAL NY or prior Waivers. Therefore, the state carved it out and put it as part of its state-only allocation.

Health Information Technology

Ms. Saunders reported that the proposed budget included \$95 million for Health Information Technology (HIT). She added that \$55 million of that allocation would be for the State Health Information Network of New York or SHIN-NY, which is often described as a health information "superhighway." Ms. Saunders explained that SHIN-NY was designed to provide statewide interoperability between the various Regional Health Information Organizations (RHIOs). She added that the SHIN-NY was described by the State Health Commissioner as the "tubes" that were used to connect the RHIOs so that, if a New Yorker gets in a car accident in Buffalo, the hospital treating him could access his records at Jacobi Medical Center to provide him with the best care possible. Ms. Saunders highlighted that SHIN-NY would be funded in a new way through the

Healthcare Reform Act (HCRA) surcharges. She explained that these healthcare surcharges were paid based on enrollees and are also called covered lives assessments. Ms. Saunders stated that, because of the increase of the number of people with health insurance under the exchange, these surcharges or covered live assessments were expected to increase. Ms. Saunders reported that, in addition to the \$65 million allocated to SHIN-NY, another \$10 million would be allocated to create the database, which would house the data on health care utilization and spending. She noted that there was a plan to make this database available to the Regional Health Improvement Collaboratives (RICs) and others. Moreover, this funding includes another \$10 million to support ongoing State Department of Health HIT needs including electronic medical records (EHRs), etc. Ms. Saunders noted that the numbers do not necessarily add up, because another \$30 million in funding is anticipated from matching federal funds.

Hospitals

Ms. Saunders reported on the hospital section of the executive budget. She stated that this section included a proposal to restore presumptive eligibility for the Modified Adjusted Gross Income (MAGI) population. She explained that this term was formerly referred to as the Aid to Families with Dependent Children (AFDC) population or people who qualify for Medicaid based on income – not the elderly or disabled. She added that, while the details of the proposal were still under scrutiny, restoring this proposal was important for HHC hospitals. She noted that it was eliminated as a by-product of the movement of Medicaid enrollment to the State Health Exchange.

Ms. Saunders reported that the budget delays hospital inpatient rebasing by three to six months (from January 1, 2014 to a time between April 1, 2014 and July 1, 2014) and would allow for periodic updates to base year of inpatient psychiatric, specialty and detoxification facilities, by no later than January 1, 2015. It also allows for adjustments to both inpatient and outpatient rates related to the implementation of the new International Classification of Diseases Version 10 (ICD-10) coding system. Ms. Saunders noted that under these proposals, rates could be adjusted to prevent a net aggregate increase in Medicaid spending.

In addition, the budget also extends the Excess Medical Malpractice Program through June 30, 2015 and continues the current eligibility. Ms. Saunders noted that this one year extension is preferable to previous budget proposals that would have reduced the number of HHC physicians that would receive coverage.

Mr. Nolan asked how long the Excess Medical Malpractice Program had been in existence. Ms. Saunders answered that this program had been in existence for quite a long time. She added that the program provided coverage for medical malpractice for high risk specialty physicians, notably obstetricians and neurologists as they have trouble accessing insurance on their own due to high rates. Ms. Brown asked Mr. Russo, HHC's General Counsel, to describe how the program worked for HHC. Mr. Russo explained that this program was designed to help providers who serve in underserved areas. The program offers a primary layer of insurance of \$1.3 million or \$3.2 million for the aggregate. In addition, the state provides an additional layer of \$1 million at no charge to the provider. He noted that the physician's primary coverage comes out of the hospital funding. Mr. Russo explained that, in order to participate in this program and qualify for this matching fund, HHC had to have an insurance carrier, which prompted HHC to form a captive insurance carrier some years ago. Ms. Brown added that this program helped to retain doctors in high need in low income communities at a time when a lot of physicians were getting out of providing care particularly for the high risk service. Those physicians could not afford the burden of very expensive medical malpractice. The program helps to maintain doctors in those areas.

Ms. Saunders continued her presentation on the hospitals section of the budget. She reported that the Governor proposed to add \$40 million for the previously mentioned Vital Access providers. Ms. Saunders added that the Vital Access Program (VAP) provided grants to essential health care providers who had been affected by system transformations like closures. She noted that this increase would bring the total funding to \$194 million. Ms. Saunders informed the Committee that to date Lincoln Medical Center, Woodhull Medical and Mental Health Center and Kings County Hospital had received a total of more than \$5 million in VAP funding. In addition, the State Health Department has received more than 150 applications totaling \$1.2 billion. Ms. Saunders underscored that VAP was one of the programs included for funding in the Medicaid MRT Waiver.

Rev. Diane Lacey, Acting Board Chairman, asked if this proposal also includes funding for hospitals affected by Hurricane Sandy. Ms. Saunders responded that the Governor's proposal was separate and apart from Hurricane Sandy claims.

Long Term Care

Ms. Saunders reported on the long term care section of the budget proposal. She stated that the Governor's budget proposal prevented Medicaid rate increases for nursing homes with rapid increases in patient acuity. She stated that this proposal was still being scrutinized as it could be a concern for HHC. She explained that, if the statewide measure of patient acuity, called the case mix index, increased more than two percent in six months, the state would proportionately reduce facilities' reimbursement rates until it fell below the two percent level. She noted that this initiative would save the state \$42.9 million beginning July 1, 2014. Also, it is intended to address what the state is calling "up coding" of rehabilitation services. Ms. Saunders highlighted HHC's concern after completion of all the work that was done at Henry J. Carter Specialty Hospital and Rehabilitation Center and Gouverneur Healthcare Services. She stated that HHC believed that it was complying with the state's

request by moving the less sick patients into less restricted settings and only retaining the ones that could only be served in a nursing home setting. She added that it was difficult to predict what the impact would be for HHC. Another aspect of the long term care proposal is that it creates a Medicaid nursing home default rate. The proposal states that, in the absence of any negotiated rate with managed care plans, nursing homes would be reimbursed the current fee-for-service Medicaid rate. Ms. Saunders noted that this initiative would not apply to rehabilitation services.

Ms. Saunders reported that the budget allocated \$350 million in funding to support a new requirement for home health care workers to be paid a living wage, or wage parity. Ms. Saunders reported that the Home Care Association was concerned about this funding amount, which is only half of the \$700-750 million needed to meet the requirements of the new law.

Ms. Saunders reported that the budget proposal also expanded affordable housing. She added that, as part of the next phase of the Medicaid Redesign Team (MRT) recommendations, the budget added 200 new supportive housing units for nursing home residents, which would raise the total to 600 units by the end of 2015. She explained that this was part of an expansion of 1,000 new beds, which would bring the total new supportive housing beds added as part of the MRT efforts to 5,550 by the end of 2015. Ms. Saunders noted that these beds would be available for nursing home residents, adult home residents and people in the homeless housing assistance program. As a member of the Medicaid Redesign Team (MRT) Housing Workgroup, Ms. Brown informed the Committee that SDOH staff who hosts that work group had asked for ideas for his next meeting later this month. She stated that HHC had partnered with three entities to submit proposals:

1. CAMBA Gardens II in Brooklyn. Learning from CAMBA I, the major issue is that rental subsidies and service supports for individuals with special medical and mental health needs is very limited. Through the NY-NY III program, the principal criteria is being homeless or in a shelter. Therefore, there are a lot of HHC patients who look like folks who are homeless or living in a shelter and who need that housing but cannot access it because they need the rental support. HHC's proposal is to take 50 of the units that are being built and get rental support for 25 years for 50 residents who are not homeless but are patients of Kings County Hospital, Dr. Susan Smith McKinney Nursing and Rehabilitation Center, Woodhull Medical and Mental Health Center and HHC's Health Homes to be able to access this housing with the rental support.
2. Communilife in Queens - HHC's proposal is to take 75 individuals from the Queens Health Network for whom rental subsidy is needed and for whom it would not have been possible to get them. A total of 125 new units to be made available for HHC patients.
3. Medical Site Respite Housing. This program is designed to serve individuals who have already been medically cleared in the inpatient units. HHC has identified these individuals, who have moved to the alternate level of care (ALOC) status and still occupying inpatient beds as a major challenge throughout HHC. Ms. Brown added that this program, with an average stay of 6-8 weeks would allow HHC to discharge these individuals into the respite program and help to finalize their housing arrangements.

Mrs. Bolus commented that some low-income pensioners are also just above the mark to meet the criteria for housing eligibility and are therefore moving to shelters. Ms. Brown clarified that this program is part of the Medicaid program and it has to be targeted to Medicaid beneficiaries. She highlighted its dual purpose as the following:

1. A cost saving objective of the state and federal Medicaid program; and
2. It is a service policy for people who should not be in skilled nursing facilities and hospitals longer than they need to be.

Ms. Brown highlighted that the program does not address that other major issue for people who are not on Medicaid, like pensioners and others, who also need in need of rental support for New York City housing.

Rev. Diane Lacey asked about veterans' eligibility for housing. Ms. Brown responded that veterans were not Medicaid beneficiaries and that there are programs for housing subsidies and support for veterans but it is not a state program.

Mr. Bernard Rosen, Board Member asked if the respite program would be different from moving the patient from an acute bed into a rehab bed. Ms. Brown responded that if the patient needed rehabilitation, that patient would go to a skilled nursing facility. She clarified that the medical site respite housing would be for patients who do not need acute care or rehab, are medically cleared by the inpatients units but need housing support. Ms. Brown explained that, rather than waiting days for housing placement in the hospital, these patients would have the opportunity to be placed in the community with support and services, but in this different setting.

Ms. Saunders reported that the last proposal concerning long term care crosses over with Managed Care. She stated that the budget included the same nursing home wage proposal advanced by the Governor in last year's budget that required nursing homes to pay standard wage and benefits to direct care workers. Ms. Saunders explained that this proposal would require managed long term care (MLTC) plans to pay nursing homes at a level to support a statewide standard wage and that the State Department of Labor would establish the amount of the wage and benefits. Ms. Saunders noted that HHC had raised its concerns last year that the proposal did not clearly exempt facilities with labor agreements or would allow regional rates to account for the increased cost of living in New York City compared to Buffalo, which could require a reduction of

wages or benefits for HHC employees. Ms. Saunders informed the Committee that this proposal had been rejected by the Legislature last year and that its status this year remained to be seen.

Managed Care

Ms. Saunders reported on the Managed Care proposals that were included in the proposed budget. She reported that the budget included a proposal to allocate \$5 million in grants to support the transition of foster care children into Managed Care. She added that the funding was intended to prepare foster care agencies for the eventual transition and to help the state collect needed data to set the rates. Ms. Saunders stated that the budget also included a proposal that would require the use of enrollment brokers for behavioral health patients. Ms. Saunders stated that, because of all the transitions into Managed Care, there had been an outcry by consumer advocates and others for more focus and attention being placed on the Medicaid Managed Care Advisory Review Panel. An addition of four new members was proposed to the panel, which would bring increase the panel to 16 members. Ms. Saunders noted that the new members would represent behavioral health consumers, consumers who are "dually-eligible" for both Medicaid and Medicare, behavioral health providers and providers caring for dually-eligible patients. The Managed Care proposal includes \$17 million to comply with the cost of new home care requirement. The State Health Department is expected to issue guidance requiring Managed Care plans to use certified home health agencies (CHHAs) to provide any skilled home care services. Ms. Saunders noted that the funding is intended to assist with the cost of providing the services through a CHHA, which is typically more expensive than providing the services through a licensed agency (LHCSA).

Behavioral Health

Ms. Saunders reported that most of the seven Behavioral Health budget proposals were focused on the move to Managed Care and integrating this population with traditional health care. These proposals are described below:

1. A proposal to create a Community Based Behavioral Health Services Reinvestment Program. The program would be funded by State General Fund savings generated by transitioning this population to Managed Care. It would be designed by the State Department of Health and the State Department of Mental Health to increase funding for community-based services for the behavioral health population.
2. A proposal to create a Collaborative Care Clinical Delivery Model. The model is aimed at clinics licensed by the State Health of Department, which are treating depression and other mental or substance abuse disorders. The State Departments of Health and Mental Health would work jointly to develop criteria to designate clinics to participate. SDOH would be authorized to waive any needed regulations and to issue new rates for the model.
3. A proposal to advance co-location of behavioral health and physical health services. The budget reallocates \$15 million from last year's budget for programs that support the co-location of services. It also allows the state to issue emergency regulation to implement the integration of co-located behavioral health and physical health services authorized as part of last year's budget
4. A proposal to provide funding for the transition to Managed Care. The budget includes \$20 million for training, HIT and transition costs related to transition of behavioral health into Managed Care. The state is authorized to provide the funding to health homes, plans, providers and others pursuant to a plan that will be developed. The transition is scheduled to begin with adults in New York City next January.
5. A budget provision to increase the rates for ambulatory services. The budget provides authority to the State Office for Mental Health (OMH) and the State Office of Alcohol and Substance Abuse Services (OASAS) to transfer funds to SDOH to pay for rate increases for ambulatory behavioral health services. The increases would be effective through January 2016 for New York City providers, except for patients under 21 where the increases would remain in place for an additional year. The proposal does allow Managed Care plans to negotiate different rates with providers.

Rev. Diane Lacey asked when the behavioral health proposals would be implemented. Ms. Saunders responded that they were expected to be rolled out by next year starting in New York City and continuing with the rest of the state. Rev. Diane Lacey asked for clarification on the idea of co-location of services. Ms. Brown responded that the idea of co-location is for a primary care clinic to have the opportunity to co-locate mental health services within that primary care facility. She added that, since it is a state program, HHC, as any other organization, could take advantage of it in its facilities. Ms. Brown highlighted that the program also worked both ways. Mental health clinics, many of which are operated by community-based mental health agencies, would also have the opportunity to co-locate a primary care clinic in their centers. Ms. Brown commented that, there are many people with chronic and non-behavioral health conditions who also experience significant mental health conditions. Their progress would not have been optimized without addressing their non-behavioral conditions. Moreover, many patients who, over the years have been getting their mental health services in a community mental health setting without there being extensive attention paid to the fact that they may also have a chronic medical illness (i.e., a heart condition, diabetes etc.) run the risk of their conditions being exacerbated over the years by psychotropic medications. Ms. Brown noted that the idea is to ensure that the whole patients' medical needs are being addressed. Ms. Brown stated that past regulations that supported segregated services had to be changed to support and reinforce integration of care as well as allocating some funds to pay for it.

Mr. Nolan commented that the benefit of co-location is the convenience of having health services housed in one facility as opposed to moving from one building to another. Ms. Brown added that the issue of co-location also showed that there is a greater chance for the patient to have that service opportunity.

Rev. Lacey added that, while the co-location concept is excellent, she would like to know how HHC would take advantage of it. She asked if it would be a separate planning and development process for HHC. Mr. Antonio Martin, Executive Vice President/Corporate Chief Operating Officer responded that, without additional state funding, that concept was already at work at HHC because it is the way for the future. Mr. Martin emphasized that the goal is to optimize patient care needs. He also added that co-location of services have proven to be very successful. Ms. Brown referred to the Finance Committee that was held earlier in the morning and stated that Mr. Aviles had mentioned that HHC had received some grants as part of the HHC's move to the next level of its Patient Centered Medical Home certification. HHC is now investing in different types of staff and expanding services. She stated that one element of that investment was the integration of behavioral and physical health care in primary care settings.

Other Issues

Ms. Saunders concluded her presentation by stating that there were a variety of other proposals that were included in the Governor's budget proposal. Many of these other proposals do not have a direct budgetary implication but are, nonetheless, important to HHC. These proposals include:

- Private equity pilot proposal. The budget includes a slightly revised proposal that was advanced as part of last year's budget. It would allow the State Health Commissioner to approve up to 5 business corporations to "assist in restructuring health care delivery systems by allowing for increased capital investment in health care facilities." They would have to affiliate with an academic medical center or teaching hospital. They could not be publicly traded. Last year, it was unclear if there was a particular venture in mind, but one of the requirements was that there had to be a pilot in Brooklyn. That is no longer included in the proposal.
- Limited services "retail" health clinics, urgent care and office based surgery. The budget would implement changes recently recommended by the Public Health and Health Planning Council (PHHPC) to license limited service clinics, require full accreditation of urgent care providers and impose more stringent requirements office-based surgery practices (beyond the current registration requirements). The Governor did propose to license retail clinics, which are typically publicly traded, as part of last year's budget.
- Nurse Practitioner Modernization Act. The Governor again proposes to modify the requirement under which nurse practitioners (NPs) would practice. As recommended by the MRT, nurse practitioners would be allowed to establish collaborative relationships with a hospital or a physician in their specialty rather than the current requirement for a written practice agreement.
- Out-of-Network Proposal. The budget includes new requirements for health plans, hospitals and other providers related to billings for health care services that are provided out of the network of approved providers covered under the patient's health care plan. This includes new notice requirements for health plans and providers, a new consumer dispute process, new reimbursement disclosure and an expansion of network adequacy requirements.
- Health Care Reform Act (HCRA) extension. The budget would extend HCRA for three years, through 2017. HCRA includes the Medicaid hospital reimbursement methodology and surcharges that fund a variety of health care program.
- HIV Testing requirements. The budget includes an overhaul of the requirements governing HIV testing. It would eliminate the requirement for written informed consent, except for patients in correctional facilities.
- Basic Health Plan. Finally, the budget authorizes the State to take advantage of an option under the Affordable Care Act (ACA) to implement a Basic Health Plan, if it is in the financial interest of the State. The State would receive any subsidies that would otherwise be available for participants to purchase coverage under the Health Exchange. The plan would cover individuals with incomes between 138-200 percent of the federal poverty level (about \$16,000 - \$23,000 for an individual or \$27,000-\$39,000 for a family of three.) The plan would be available for many legal immigrants who cannot qualify for Medicaid due to their immigration status (but not for the undocumented).

Ms. Brown thanked Ms. Saunders and John Jurenko, Senior Assistant Vice President for the 2014-15 State Fiscal Year Executive Budget overview presentation.

Ms. Anna Kril, Committee Member, asked about individuals, such as pensioners and veterans, who are falling between the cracks. She commented that these individuals, who have worked all their lives, suffer enormous hardships because they are slightly below the eligibility mark for Medicaid and are out of the loop of all of these available programs. Ms. Brown answered that this issue should be raised consistently for those individuals who are just below the income requirements for Medicaid; and because they are not Medicaid beneficiaries they are not

entitled to some of these programs. Ms. Brown suggested that the issue should be raised with their Congressional representatives as some of these issues are part of federal rules. For example, with Housing and Development (HUD), there are some HUD requirements very specific to certain incomes. Housing developments using either HUD dollars or Section-8 for rental assistance, there is an income guideline and some of the pensioners do not meet those income guidelines. Ms. Brown emphasized that these programs are federal programs and federal representatives would have to change these programs to address these issues. Whether there is enough housing for veterans or enough incentives for developers, the issue is how to finance that housing. The federal government has to provide incentives to create that housing for it to be built. Ms. Brown stated that the city and the state have tried to take full advantage of federal rules, to leverage state dollars, to leverage city opportunities (parcels of land and other) to pull together within the constraints of the federal rules, opportunities to create housing for low income individuals, homeless individuals, Medicaid beneficiaries. She added that the way to address these issues is about people coming into a room and saying that something must be done and using the political process to make it happen. For example, KCHC CAB members were engaged in the CAMBA Ventures in Brooklyn and had called upon their Brooklyn delegation to surface this issue. The same process can be done in all the boroughs. While federal change involves all federal officials, it is possible to start raising the issue with the New York State delegation.

SUBSIDIARY REPORT

MetroPlus Health Plan, Inc. - February 11, 2014 As reported by Mr. Bernard Rosen

Chairperson's Remarks

Chair Rosen welcomed everyone to the first MetroPlus Board of Directors meeting of 2014. Chair Rosen stated that Dr. Saperstein would present the Executive Director's report and Dr. Dunn would report on Medical Management issues.

Executive Director's Report

Dr. Arnold Saperstein reported that total plan enrollment as of January 1st, 2014 was 424,478. Breakdown of plan enrollment by line of business is as follows:

Medicaid	362,516
Child Health Plus	11,678
Family Health Plus	26,430
MetroPlus Gold	3,501
Partnership in Care (HIV/SNP)	5,312
Medicare	7,860
MLTC	465
QHP	9,637
SHOP	465

Dr. Saperstein stated that MetroPlus membership has increased since his last report to the Board. The Plan gained over 9,700 Exchange members this month, with the implementation of its Qualified Health Plan offerings on the New York State of Health (NYSoH).

In regards to the NYSoH, as of January 13th, over 230,000 New Yorkers enrolled in the NYSoH. As of January 13th, 2014, MetroPlus received over 21,000 completed applications and have over 11,000 paid members. The Plan has also received its first files with Medicaid enrollments, and has approximately 2,400 new Medicaid members. Each of the 16 health plans offering coverage through NY State of Health enrolled members into Qualified Health Plans (QHP). Six plans each enrolled 10 percent or more: Empire (18%), Health Republic (16%), Fidelis (14%), Emblem (12%), MetroPlus (11%), and MVP (10%). Six percent of enrollees are enrolled in Excellus, and the remaining 13 percent of enrollees were spread across nine issuers, each of which enrolled one to two percent of QHP enrollees. In addition, 37% of all of the state's enrollees were from New York City. Considering its numbers, it appears that MetroPlus received 25% of all of the Exchange enrollees in New York City.

In mid-December, the Exchange clarified that MetroPlus' Certified Application Counselors (CACs) are permitted to accept premium payments directly from prospective enrollees if the enrollee has selected MetroPlus. This will allow prospective members yet another method to pay their premiums. In addition to mail-in payments, MetroPlus also accepts premiums from members that are visiting its main offices to remit their premium payments. MetroPlus currently accepts credit card payments, and are in the final stages of adding electronic payments to its website, to make it easier for members in the near future.

Dr. Saperstein reported that, after months of preparation to join the Fully Integrated Duals Advantage (FIDA) program, reviewers from New York State and CMS conducted their two day site review January 14th, 2014. In preparation, MetroPlus conducted mock audits and sharpened workflows to ensure that all areas were prepared for the review. The Plan anticipates a successful site visit and will share results with the Board as they are made available.

In December, the State Department of Health posted the Regional Consumer Guides for 2013. The Guides provide ratings of the health plans on Preventive and Well-Care for Adults and Children, Quality of Care Provided to Members with Illnesses, and Patient Satisfaction with Access and Service. MetroPlus Health Plan was rated number 2 of all Medicaid Managed Care Plans in New York City with an overall rating of 70%.

Medical Director's Report

Dr. Van Dunn stated that, on January 13, 2014, MetroPlus held the 2013 QARR Awards at Metropolitan Hospital Center. Mr. Antonio Martin, HHC Executive Vice President, provided opening remarks and Dr. Ross Wilson, HHC Chief Medical Officer, provided closing remarks. MetroPlus chose 19 HEDIS/QARR measures including three measures from the Consumer Assessment of Healthcare Providers and Systems: Getting Needed Care Quickly, Rating of Specialist, and Rating of Healthcare as the basis for the distribution of the awards. A facility received \$10,000 if they had the highest rate for a measure. If there was a tie, the facilities each receive \$10,000. In addition, the Plan awarded \$60,000 to the facility who was ranked 1st place overall, \$30,000 to the facility ranked 2nd place overall, and \$20,000 to the facility ranked 3rd place overall.

Gouverneur was ranked 1st place overall and received \$60,000, which was the most awarded to any facility. Elmhurst Hospital Center and Kings County Hospital each received \$30,000 which was the second highest amount awarded to any facility. Coney Island Hospital received \$20,000, which was the 3rd highest amount received by any facility.

Dr. Dunn reported that, as part of MetroPlus Health Plan's continuing efforts to provide health education and valuable information to our members, it completed several mailings. As part of the Diabetes Performance Improvement Project, the Plan sent a readmission prevention mailing to all diabetics who were admitted to the hospital over the past 6 months and to their providers about the importance of glucose control, and regularly scheduled visits to their primary care provider. A general diabetes mailing was sent out to about 28,000 members this month. The mailing included information about MetroPlus' Diabetes Case Management Program, diabetes education resources, personal diabetes care card and a discount at YMCA health club. The personal diabetes care card promotes diabetes self-care means. The member is in charge of making healthy choices every day to help keep blood sugar levels as close to normal as possible. Members can take the card with them when they visit the doctor or diabetes educator so that they can have a record of their diabetes control. The diabetes care card has their providers and contact information, exam and tests results (BP,HgA1C, Cholesterol, eye, foot and dental exam, medications and diabetes self-management plan (exercise, meal plan, foot care).

Dr. Dunn stated that, in efforts to improve medication adherence among our members with chronic diseases, the Plan sent a medication adherence report to 1,314 primary care providers. This report served as a reminder to the PCP that the patients were due for a prescription refill. MetroPlus received mixed feedback related to this mailing. Some providers called in with praise for the opportunity to outreach their non-adherent members while others called to report that the listed member is no longer attending their medical practice.

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

**ALAN D. AVILES
HHC PRESIDENT AND CHIEF EXECUTIVE
REPORT TO THE BOARD OF DIRECTORS
FEBRUARY 27, 2014**

FOURTH ANNUAL JOINT LABOR-MANAGEMENT PATIENT SAFETY FORUM

On February 3, the Office of Patient and Employee Safety continued its collaboration with the Committee of Interns and Residents/SEIU Healthcare and the New York State Nurses Association by hosting a Joint Labor Management Patient Safety Forum. This invitation only conference brought together a representative group of frontline clinical teams and leadership staff from each HHC hospital to discuss how to improve patient safety and quality by examining the root causes of errors. The goals of the one-day conference were to: understand what it means to be truly "patient-centered"; improve patient safety outcomes by understanding the root causes of errors; and improve communication and teamwork within interdisciplinary teams.

The morning began with a presentation on the results of the HHC-CIR/SEIU Resident Patient Safety Survey given by Mei Kong, RN, AVP Patient and Employee Safety and Samrina Kahlon, MD, Patient Safety Officer, Metropolitan Hospital, NY Regional VP CIR/SEIU. The keynote presentation *"Improving Patient Safety Outcomes by Understanding the Root Cause of Errors"* was delivered by James F. Pelegano, MD, Assistant Professor and Program Director at the Jefferson School of Population Health.

In the afternoon, teams focused on identifying the barriers to reporting errors and to establishing a Just Culture, led by Mei Kong and Say Salamon, MD, PGY-3, Woodhull Hospital, NY Regional VP CIR/SEIU. Ann Bove, RN, Bellevue Hospital Center, Secretary, NYSNA Board of Directors, presented on Communication and Teamwork for Patient Safety; and David Eshak, MD, PGY-3, Jacobi Medical Center, NY Regional VP, CIR/SEIU led a final discussion on barriers to reporting and next steps.

Despite a snowstorm, 200 individuals attended the Forum and approximately 150 others participated via live streaming.

**LEADERSHIP DEVELOPMENT PROGRAM
GRADUATION OF SECOND COHORT OF MIDDLE MANAGERS**

On January 28, the second cohort of HHC facility middle managers and their coaches completed the Corporate Leadership Development program conducted by the Advisory Board Company. The 114 participants and 36 coaches attended five full day sessions, which focused on the Healthcare Management Intensive, Critical Thinking and Problem Solving, Instilling Accountability, Facilitating Effective Teamwork, and Impact through Influence. The coaches also participated in a half-day session on Coaching for Full

Potential.

Coaches worked with the managers on over 100 individual and group projects designed to reinforce what was learned in the sessions. In addition to Advisory Board content, participants were required to complete Breakthrough Green training (if they had not already done so), finance training conducted by CFO Marlene Zurack, and Media Relations training held by Senior VP Ana Marengo and Bellevue Associate Executive Director Evelyn Hernandez.

Kudos to Caroline Jacobs for leading this important initiative. To date, 294 managers and senior leader coaches have now participated in this leadership development program. This initiative is part of our investment in developing our workforce and is a central component of our Workforce Development Strategic Plan.

The third cohort is scheduled to begin in May 2014.

ADDITIONAL CANCERS TO BE FEDERALLY FUNDED WHEN TREATED BY HHC'S WTC ENVIRONMENTAL HEALTH CENTER

Our World Trade Center Environmental Health Center was pleased to recently learn the federal government has added to the list of covered cancer conditions related to 9/11 exposures. When the James Zadroga 9/11 Health and Compensation Act was enacted in 2011 -- the federal legislation which created the federal World Trade Center Health Program -- no cancers were covered. But in September of 2012 over 50 cancers were appended as WTC-related conditions, and then a year later, in September of 2013, prostate cancer was added. As of last week, now included are malignant neoplasms of the brain, cervix, pancreas and testis. We estimate at least three dozen of our current patients, who were not previously covered for these conditions, now will be. This expanded list of covered cancers will also be likely to encourage additional eligible people to enroll.

HHC WINS NATIONAL AWARD FOR SUPPLY CHAIN SYSTEM

HHC was one of 12 healthcare organizations across the United States to receive the Emergency Care Research Institute's (ECRI) 2014 Healthcare Supply Chain Achievement Award. The winning organizations were chosen out of nearly 3,000 hospitals and health systems who subscribe to the Institute's supply and capital procurement advisory services. The award honors organizations for excellence in overall procurement spend management and in adopting best practice solutions in their supply chain process. HHC was recognized for its performance in reducing costs, utilization, and readmissions while achieving better healthcare outcomes.

ECRI is an independent, nonprofit organization that researches the best approaches to

patient care. It is designated as an Evidence-Based Practice Center by the federal Agency for Healthcare Research and Quality. It is also a Collaborating Center of the World Health Organization.

HHC CAMPAIGN HIGHLIGHTS LIFE-SAVING COLON CANCER SCREENING

HHC will once again recognize National Colorectal Cancer Awareness Month in March by educating our patients, staff and the public at large about the benefits of colon cancer prevention, screening and early detection. We will use all communications platforms available to us -- from internal email blasts to social media -- to remind New Yorkers who are approaching 50 to get a colonoscopy or ask about other effective colon cancer screening tests available. HHC physicians will spread our colon cancer message in op-ed columns in the Epoch Times, Harlem News, Brooklyn Spectator, Queens Courier, El Diario, El Especialito and The Chief Leader. Other campaign elements will include posters, post cards, email messages, our website, a press release, banners, and screen savers. HHC will also collaborate with members of the Citywide Colon Cancer Control Coalition (C5) to create awareness through a dedicated web page and unified social media campaign.

FEDERAL UPDATE

\$8 Billion Medicaid Waiver

On February 13, New York State reached an agreement in principle on a federal waiver that will give the state \$8 billion in additional federal Medicaid funding over five years, which is lower than the state's \$10 billion request. The federal program is intended to stabilize the healthcare delivery system, focus on primary and preventive care and cut avoidable hospitalizations and emergency department use. Waiver money will flow to hospitals and other healthcare facilities based on performance and outcomes measures of specific projects. HHC plans to apply for funding from the waiver, the terms of which are still being negotiated.

The "Two-Midnight" Rule

In response to advocacy from hospital groups, physicians and others, on Friday, January 31st, the federal Centers for Medicare and Medicaid Services (CMS) announced a six month delay until September 2014 of the enforcement of the "two-midnight" rule.

This rule was promulgated by CMS reportedly to address patients' concerns with long "observation" stays. While welcome, the recent delay in enforcement by CMS did not alter the underlying policy of arbitrarily using two midnights to determine when an inpatient admission is justified for reimbursement purposes. It also fails to address the provider community's concern with developing a new payment policy for short inpatient

high acuity stays and does not guarantee that the issue will be addressed in the proposed inpatient payment rule this April. The current rule, if implemented, could cost HHC from \$23-38 million a year in lost revenue.

During the delay period, contractors will continue to carry out "probe and educate" prepayment reviews on a sample of inpatient claims with dates of admission from October 1, 2013 through March 31, 2014. The probe and educate reviews are intended to determine if hospital inpatient claims comply with the "two-midnight rule." Those that fail to comply with the new benchmark requirements will be denied. The probe reviews affect acute care hospitals, long-term care hospitals and inpatient psychiatric hospitals.

Despite the delay by CMS of the enforcement of the two-midnight policy until the end of September, HHC and other hospital groups continue to pursue, through both administrative and legislative avenues, the establishment of a rational short-stay payment mechanism under the Medicare inpatient system.

The "Doc Fix"

A bipartisan group from both houses of Congress is currently working on legislation to replace the Sustainable Growth Rate (SGR) formula that has limited physician reimbursement under the Medicare Program since its enactment as part of the Balanced Budget Act (BBA) of 1997. The limitation has been suspended many times since, with the latest expiring on March 31st.

Congress views this year as a very promising window to remedy this problem permanently because the Congressional Budget Office (CBO) has estimated that a permanent fix would cost the federal government \$116.5 billion over ten years - about half the estimate in years past - primarily due to lower projections in the growth of Medicare expenditures.

Remarkably, the three relevant congressional committees, House Ways and Means, House Energy and Commerce and the Senate Finance, have come to an agreement on a permanent fix, including new requirements that reward quality and value over volume.

The big risk for HHC and the hospital provider community relates to how the provisions of the bill may be funded. Among the sources being considered to pay for the "doc fix" are many of the hospital reimbursement reductions opposed for the last several years by HHC and others in the hospital advocacy community. These include: Medicaid Disproportionate Share Hospital (DSH) rebasing for additional years (a loss of \$495 million to HHC each year when including the local share); Hospital Outpatient Department reimbursement reductions that will greatly impact hospitals serving low

income or rural populations where there are few neighborhood physicians (loss of \$187 million to HHC over 10 years); and reducing payments for Graduate Medical Education (\$215 million loss to HHC over 10 years).

It should be noted that funding the SGR patch of December 2013, which cost \$7 billion, included an added year of Medicaid DSH reductions to 2023 as well as new criteria governing Long Term Care Hospitals which, as reported last month, will have a negative impact on HHC's Henry J. Carter facility. We will keep you posted on any developments in this area.

Medicare 2% Provider Reimbursement Cut Extended

On February 12, Congress passed legislation that restored the Military Retiree COLA. In a disturbing pattern, however, Congress chose to pay for this through an extension until 2024 of the 2% Medicare Provider reimbursement reduction, which was originally enacted as part of the sequester. This continuing Medicare sequester cut will cost HHC \$18 million a year.

ACA Employer Mandate Rules Issued

On February 10, the Obama Administration issued Treasury rules providing significant transition flexibility for the ACA employer mandate.

The final rule gives employers with 50 to 99 full-time workers an additional year to phase in employer-mandated compliance and it delayed penalties until January 1, 2016, though they will still have reporting requirements in 2015. A crucial condition for receiving the transition relief is that employers must certify that they haven't laid off employees in order to come under the 100-employee threshold.

Beginning January 1, 2015, employers with more than 100 full-time equivalent employees must comply with the final rules. The final rule also phases in the percentage of full-time workers that the largest employers need to offer coverage to from 70 percent in 2015 to 95 percent in 2016 and beyond.

The employer-shared responsibility rules generally provide that employers may face penalties if they don't offer full-time employees and their dependents affordable, minimum value healthcare coverage.

Health Exchange Enrollment

Thus far, HHC's health plan, MetroPlus, has enrolled 18,000 newly insured members through the new Health Exchange, and has gained about 10,000 new Medicaid members through the Exchange as well. Nearly another 10,000 applications are pending

and would become active enrollments upon payment of the first month's premium.

HHC UPDATE TO CITY COUNCIL HEALTH COMMITTEE ON COST CONTAINMENT AND RESTRUCTURING

On February 24, at the request of the Health Committee of the City Council, I testified and gave an update on the various initiatives that are part of HHC's cost containment and restructuring plan. I provided some historical context to explain why we needed to undertake significant cost-containment and restructuring efforts over the last several years, pointing out that our safety-net role has made us especially vulnerable to deep cuts to Medicaid, the cost of serving a rising tide of uninsured patients, and the erosion of federal funding. I outlined our basic fiscal situation and challenges and then reviewed the Road Ahead initiatives and the principles that guided their implementation. I pointed out that, despite our progress, future budget deficits loom and could be made deeper by the pending labor arbitration outcomes and further federal budget cuts.

A number of council members were very interested in our contractual joint venture around the provision of acute and chronic dialysis and I responded to questions related to continuation of quality and access to services. There were also a number of questions about our timing for the re-opening of maternity services at North Central Bronx Hospital. I indicated that we expected to have a formal staffing plan for both inpatient maternity services and the NICU completed next month and that we would be formally asking the State Health Department to extend our time for re-opening the service for several months. We anticipate that it will take until sometime this summer to identify and on-board a full complement of staff for all tours.

HHC VOLUNTEERS ARE RECOGNIZED

More than 8,000 New Yorkers volunteer in HHC hospitals and health centers every year. Several of these generous volunteers have recently been specially recognized.

The United Hospital Fund is recognizing Bellevue Hospital volunteer Anthony (Tony) Austin with its 2014 Hospital Volunteer Achievement Award. Mr. Austin works three to four days per week telephoning patients to remind them of their therapy session appointments, informing waiting patients when the therapist is ready to see them, and escorting them to and from their sessions. Mr. Austin's accomplishments are all the more remarkable because he has been a paraplegic since 1983 when, as a cab driver, he was shot while driving his cab. He was treated extensively at Bellevue and has now been a volunteer there for more than 10 years.

Another volunteer was celebrated when former Schools Chancellor Dennis Walcott, a lifelong Queens native, spent the month of January volunteering at Queens Hospital Center (QHC). While volunteering, Mr. Walcott spent time in the Emergency Room,

Pediatric Clinic, Adult Ambulatory Care Department, and several other outpatient and inpatient departments and units to observe how medical staff communicate with and engage patients. Mr. Walcott gave an hour-long, insightful presentation at QHC about his volunteer experience.

DR. YVETTE CALDERON OF JACOBI WINS LAUBENSTEIN AWARD FOR HIV CARE

Yvette Calderon, MD, has been recognized by the New York State Department of Health with the Laubenstein Award for her decades of work in HIV/AIDS prevention efforts. Dr. Calderon, an emergency department physician and chief of Urgent Care at Jacobi Medical Center, has helped lead HHC's efforts to combat HIV/AIDS through a variety of innovative programs that engage underserved communities and at-risk populations.

In 2003, Dr. Calderon partnered with Dr. Jason M. Leider, medical director of the North Bronx Health Network's Adult HIV Services, to develop and implement Project B.R.I.E.F. seeking to boost HIV awareness through rapid testing in non-traditional testing environments such as emergency departments. Research shows that this form of non-traditional testing more effectively reaches high-risk populations that have not otherwise been tested for HIV/AIDS. More than 100,000 Bronx residents have been tested due to her work as programs throughout New York City have adapted her work for their HIV testing and care efforts. Rapid testing is now commonly performed at all HHC hospitals and health centers.

I know the board joins me in congratulating Dr. Calderon on receiving this well-deserved recognition.

SNUG PROGRAM AT JACOBI RECEIVES NEW YORK STATE GRANT FOR VIOLENCE PREVENTION

The Jacobi Medical Center Auxiliary Inc., in partnership with Fellowship Tabernacle Ministries, Inc., Physicians Affiliate Group of NY, and Jacobi Medical Center, have received \$300,000 for the Neighborhood Violence Prevention Project, an injury prevention program incorporating a multi-pronged approach to prevent shootings and violence involving young adults in Bronx County. The program was announced by the governor and received news coverage in many media outlets.

The program is named SNUG - "guns" spelled backwards. Jacobi will implement the evidence-based Cure Violence Model, relying on culturally appropriate staff -- often former gang members -- who respond to shootings and prevent retaliation through focused outreach. Moreover staff members also detect and resolve conflicts that are likely to lead to shootings and prevent retaliation. An extensive schedule of social and recreational programs specifically designed to appeal to an at-risk population will be implemented. Jacobi Medical Center will provide expert medical leadership including

pediatric, adolescent and emergency medicine specialists, as well as a hands-on intense social work component.

SECOND PRINT EDITION OF HHC INSIDER RELEASED

This week, HHC's Internal Communications Group (ICG) released the late-winter edition of the HHC Insider, a print publication that features some of the most popular stories that appear on the Insider intranet homepage. This issue's leading story introduces HHC's six Guiding Principles and includes a special message from Dr. Ramanathan Raju, HHC's next President and CEO. In this issue, readers will also find articles about the Patient-Centered Medical Home, The Fund for HHC, the upcoming relocation of some Central Office groups to new offices, and the soon-to-be-launched ICD-10 coding system.

The inaugural print issue of the HHC Insider was published in November 2013. The current issue, which is in the Board's packets, will be distributed throughout HHC this week. The Insider is produced and published by ICG, which develops and shares useful, relevant, and interesting information with HHC staff across the system. You can read materials produced by ICG by visiting HHC's intranet, which is updated daily, at intranet.nychhc.org.

HHC BIDS FAREWELL TO LYNDA CURTIS

After 40 years of unparalleled service to HHC and our patients, Lynda D. Curtis has announced her retirement effective March 2. Ms. Curtis retires as Senior Vice President of the South Manhattan Network with administrative oversight of Bellevue, Metropolitan, Gouverneur, Coler, and the new Carter facility. She was also, until November 2013, Executive Director of Bellevue. Throughout her career, which began in 1974 as a children's counselor at Sydenham Neighborhood Family Care Center, Lynda Curtis represented the best of HHC -- deep compassion, dedication to improving the health status and safety of patients, unflagging energy, profound integrity, and a commitment to promoting opportunity for all staff. Additionally, Ms. Curtis ably represented HHC in various local and national healthcare forums, where she was widely regarded as the best of the best.

I have mixed emotions about Lynda's imminent departure. I am thankful for the professional relationship that we shared at HHC, glad for her opportunity to now enjoy what will undoubtedly be an active and engaged retirement, and sorry to lose a colleague who combined keen intelligence, strategic vision, and inspiring leadership with personal warmth and kindness. In thanking Lynda Curtis for her service, I know that I speak for thousands of HHC staff who have had the pleasure of working for her, with her, or looking to her as an example of what can be achieved in a career well-

spent.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

Dr. Eric Legome, of Kings County Hospital, says flu season has been less intense due to more vaccinations, Dr. Eric Legome, Kings County, News 12 Brooklyn, 2/3/14

Doctors see increase in patients suffering from Seasonal Affective Disorder this winter, Dr. Michael Adams, Lincoln, News 12 Bronx, 2/4/14

Doctors Warn About Dangers and Accessibility of Synthetic Drugs, Dr. Ronnie Swift, Chief of Psychiatry, Metropolitan, NY1, 2/10/14

Number of Kids Visiting Hospital for Asthma Dropping Fast in Harlem, Metropolitan, NY1, 2/25/14

Death of actor Philip Seymour Hoffman highlights growing heroin problem, Dr. Alla Borik, Lincoln, News 12 Brooklyn, 2/4/14

Anti-Gun Program is a SNUG Fit, Jacobi, NY1, 2/8/14

Best of the Bronx: Jacobi Medical Center's Dr. Yvette Calderon honored for HIV prevention, News 12 Bronx, Newsday (Video) 2/7/14

Rally to demand reopening of maternity ward at North Central Bronx Hospital in Norwood North Central Bronx, News 12 Bronx, 2/25/14

Print

MetroPlus racks up numbers on exchange, HHC, MetroPlus, Capital New York, 2/20/14

Hospitals' Dialysis Plan Is Under New Scrutiny, President Alan D. Aviles, HHC, The New York Times, 2/12/14, (Also covered in Crain's Health Pulse)

De Blasio faces growing public hospitals deficit, President Alan D. Aviles, Crain's New York Business, 2/24/14 (Also covered in Capital New York)

New Bronx program teaches teens new ways to solve conflicts, Jacobi, New York Daily News, 2/7/14

SNUG comes to the Bronx, Dr. Sheldon Teperman, Dr. Stephen Blumberg, Jacobi, The

Bronx Times, 2/14/14 (Also covered in Newsday)

Residents vote to demolish historic Queens Hospital Center T Building but preservationists vow to fight back, Queens, New York Daily News, 2/4/14

On the Record With...Dr. Robert Gore Dr. Robert Gore, Kings County, BET, 2/7/14

How to Stop Heroin Deaths, Dr. Robert S. Hoffman, Bellevue, The New York Times, 2/6/14

The plague of synthetic drugs, Dr. Ronnie Swift, Metropolitan, Manhattan Times, 2/5/14

Psychotherapy May Be Effective Alternative Treatment for Schizophrenia, Study Finds, Dr. Mary Badaracco, Bellevue, Health Day, 2/7/14 (Covered in multiple media outlets, including U.S. News and World Report and Health Medicine Net)

A Weighty Matter for Pediatric Medication Dosing, Dr. Muhammad Waseem, Lincoln, Emergency Medicine News, February 2014

During Black History Month Ceremony, Coney Island Hospital Honors Borough President Eric Adams, Sheepsheadbites, 2/20/14

Sea View Hospital Rehabilitation Center and Home elects new officers, Angelo Mascia, Executive Director, Staten Island Advance, 2/11/14

Lincoln Medical Center Opens Psychiatric In-Patient Unit, Amsterdam News, January 23-29, 2014

Lincoln Announces Mental Health Expansion, Mott Haven Herald, January 10, 2014

What every expectant mother should know (part 2), Dr. Malvina Elmadjian, Lincoln, Bronx Free Press, January 29, 2014

Prevent Cardiovascular Disease: Know Your Risk and Numbers!, Dr. Lekshmi Dharmarajan, Lincoln, Bronx Free Press, 2/19/14

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to purchase computer workstations, laptops, and IT peripherals for the entire Corporation through Third Party Contract(s) from various vendors on an on-going basis in an amount not to exceed \$7,200,000, over a 12 month period, which includes a 10% contingency of \$654,545.50.

WHEREAS, the Corporation has an inventory of approximately 34,500 computer workstations including mobile laptops; and

WHEREAS, the recommended refresh cycle for desktop PCs is three to four years and for portable laptops is two to three years; and

WHEREAS, in Calendar Year 2014, approximately 8,500 units will be replaced, based on a four year refresh cycle; and

WHEREAS, EITS’s strategy is to standardize equipment with one manufacturer and limit the number of computer workstation models in order to maintain a standard environment; and

WHEREAS, Third Party Contracts offer discounted pricing compared to the market price for such equipment; and

WHEREAS, through volume purchasing via Third Party Contracts, EITS was able to procure PCs and Laptops with savings of approximately \$1.7 million this past year; and

WHEREAS, the accountable person for this purchase is the Senior Vice President/ Corporate Chief Information Officer.

NOW, THEREFORE, be it:

RESOLVED, THAT THE President of the New York City Health and Hospitals Corporation be and hereby is authorized to purchase computer workstations, laptops, and IT peripherals for the entire Corporation through Third Party Contract(s) from various vendors on an on-going basis in an amount not to exceed \$7,200,000, over a 12 month period, which includes a 10% contingency of \$654,545.50.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to purchase storage hardware, software, and associated maintenance from various vendors on an on-going basis via Third Party Contract(s) in an amount not to exceed \$7,200,000 for a one year period, which includes a 10% contingency of \$654,545.50.

WHEREAS, the Corporation has over 5.0 petabytes of storage, which is utilized to store the Corporation’s email, business and clinical data applications as well as surveillance video systems; and

WHEREAS, this storage is configured to be highly available and provide disaster recovery protection for mission critical business and clinical applications used for patient care; and

WHEREAS, in order to keep up with the demand of storing mission critical data and providing continuous access to our email, business and clinical data applications as well as surveillance video systems, the Corporation must continuously upgrade and add additional storage to our Storage Area Network; and

WHEREAS, the Corporation will solicit proposals from manufacturers and authorized resellers on an on-going basis via Third Party Contract(s); and

WHEREAS, Third Party Contracts offer discounted pricing compared to the market price for such equipment;

WHEREAS, the accountable person for this purchase is the Senior Vice President/ Corporate Chief Information Officer.

NOW, THEREFORE, be it:

RESOLVED, THAT THE President of New York City Health and Hospitals Corporation be and hereby is authorized to purchase storage hardware, software, and associated maintenance from various vendors on an on-going basis via Third Party Contract(s) in an amount not to exceed \$7,200,000 over a one year period, which includes a 10% contingency of \$654,545.50.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to purchase networking hardware, software and related consulting and technical services through various vendors via Third party contracts on an on-going basis in an amount not to exceed \$28,300,000 in capital funds for a networking infrastructure refresh program over a two year period.

WHEREAS, the Corporation has an inventory of approximately 200 routers, 1,500 switches and over 3,000 wireless access points that are utilized to link various computers and data systems throughout the Corporation in order to share business and clinical applications used for patient care; and

WHEREAS, industry standards for the refresh of networking equipment is typically three to five years depending on equipment type; and

WHEREAS, the Corporation’s end of life network infrastructure must be replaced in order to avoid any outages associated with equipment/part failures, software glitches and software upgrades that are utilized to optimize network performance, and failure to refresh network infrastructure equipment can result in system unavailability, which may adversely impact patient care; and

WHEREAS, EITS will also be installing an enterprise wireless network throughout the organization that will transform patient care by providing clinicians with the capability of handheld wireless devices to provide patient care and provide wireless access to the patient community; and

WHEREAS, EITS will also replace the existing Private Branch Exchange (PBX) with an agile phone system Voiceover Internet Protocol with full Business Continuity throughout the HHC environment; and

WHEREAS, the Corporation will solicit proposals from authorized vendors who offer networking hardware, software and services via Third Party contracts; and

WHEREAS, the Third Party contract prices for such infrastructure are discounted from market price; and

WHEREAS, purchase orders will be issued to the vendors offering the lowest price for the requested hardware and software; and

WHEREAS, the accountable person for this purchase is the Senior Vice President/Corporate Chief Information Officer.

NOW, THEREFORE, be it:

RESOLVED, THAT THE President of New York City Health and Hospitals Corporation be and hereby is authorized to purchase networking hardware, software and related consulting and technical services through various vendors via Third party contracts on an on-going basis in an amount not to exceed \$28,300,000 in capital funds for a networking infrastructure refresh program over a two year period.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to initiate the planning for a construction program of improvements throughout the Corporation to support an information technology equipment modernization and replacement plan with upgrades to heating, ventilation and air conditioning ("HVAC") and electrical equipment at a total approximate cost of \$15 Million over the next two years subject to further authorization by the Capital Committee of the components of such construction program.

WHEREAS, the Corporation has an inventory of approximately 200 routers, 1,500 switches and over 3,000 wireless access points that are used to link to various computers and data systems throughout the Corporation; and

WHEREAS, such equipment requires upgrade and/or replacement on schedules of 3 – 5 years depending on equipment type; and

WHEREAS, to complete the equipment upgrade and/or replacement it is necessary to retrofit the closets holding intermediate distribution and main distribution frames with electrical and HVAC upgrades to ensure uninterruptible or back-up power sources and HVAC must be provided or upgraded; and

WHEREAS, the necessary construction work has been preliminarily estimated at \$15 Million with the costs at various of the Corporation's facilities ranging from close to \$7 Million to only \$100,000; and

WHEREAS, the procurement method appropriate for the contemplated work will vary across the Corporation depending on the amount of work required at each facility and the nature of the work; and

WHEREAS, to properly refine the budget for the work and determine the best procurement methods to be used for the various components of the construction program, the Corporation must engage architects or engineers to develop plans for such work; and

WHEREAS, the Corporation shall use the services of architects or engineers already under requirements contracts with the Corporation to prepare the necessary plans.

NOW THEREFORE, the President of the New York City Health and Hospitals Corporation be and he hereby is authorized to initiate the planning for a construction program of improvements throughout the Corporation to support an information technology equipment modernization and replacement plan with upgrades to heating, ventilation and air conditioning and electrical equipment at a total approximate cost of \$15 Million over the next two years subject to further authorization by the Capital Committee of the components of such construction program.

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 New York Legal Assistance Group (the "Licensee") for part-time, non-exclusive use and occupancy of space at Bellevue Hospital Center, Coler Nursing Facility, Coney Island Hospital, Elmhurst Hospital Center, Harlem Hospital Center, Henry J. Carter Specialty Hospital & Nursing Facility, Jacobi Medical Center, North Central Bronx, Kings County Hospital Center, Lincoln Medical & Mental Health Center, Metropolitan Hospital Center, Queens Hospital Center and Woodhull Medical & Mental Health Center (the "Facilities") to provide legal services to patients and training to Corporation staff at an annual fee of \$55,000 per clinic, per facility year one and two and \$60,000 per clinic per facility year, three, four and five payable by the Corporation to the Licensee and without any payment by the Licensee for the use of the space.

WHEREAS, the Licensee is a not-for-profit provider of legal services to, among others, hospital patients in need of counseling in various areas of the law, including, but not limited to, immigration, domestic relations, child support and custody, and benefit entitlements; and

WHEREAS, the Licensee's program also consists of training the Corporation's staff to assist the Licensee in recognizing patients in need of legal services; and

WHEREAS, the Board of Directors of the Corporation has previously authorized the President to enter into license agreements with the Licensee to provide such training and legal services at Bellevue Hospital Center, Coler-Goldwater Specialty Hospital and Nursing Facility, Elmhurst Hospital Center, Harlem Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical & Mental Health Center, and Woodhull Medical & Mental Health Center; and

WHEREAS, the Licensee's services will continue to be provided at the facilities previously authorized by the Board and services will also be provided at Coney Island Hospital Center, Metropolitan Hospital Center, Henry J. Carter Specialty Hospital and Nursing Facility Queens Hospital Center and North Central Bronx

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a five year revocable a license agreement with the New York Legal Assistance Group (the "Licensee") for its part-time, non-exclusive use and occupancy of space at Bellevue Hospital Center, Coler Nursing Facility, Coney Island Hospital, Elmhurst Hospital Center, Harlem Hospital Center, Henry J. Carter Specialty Hospital & Nursing Facility, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical & Mental Health Center, Metropolitan Hospital Center, Queens Hospital Center and Woodhull Medical & Mental Health Center (the "Facilities") to provide legal services to patients and training to Corporation staff at an annual fee of \$55,000 per clinic per Facility payable by the Corporation to the Licensee for the first two years of the license term and \$60,000 per clinic per Facility per year thereafter and without any payment by the Licensee for the use of the space.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a 99-year sublease with CAMBA Housing Ventures, Inc. ("CHV") or a not-for-profit housing development fund corporation in which CHV is the sole member, or a limited partnership or limited liability company in which the general partner or managing member, as applicable, is an affiliate of CHV for the development of low-income housing, and housing for the formerly homeless on the site of the "G Building," a parcel of land on the campus of Kings County Hospital Center (the "Facility") of approximately 97,000 square-feet at a fair market value rent established by appraisal which is currently anticipated to be not more than \$2.5 Million in total.

WHEREAS, since 1977, CAMBA, a non-profit organization based in Brooklyn, New York, has been providing services in New York City which include homelessness prevention, housing relocation, emergency and transitional housing, and permanent affordable and supportive housing; and

WHEREAS, CHV, is a not-for-profit corporation affiliated with CAMBA and incorporated in 2005 for the purposes of undertaking supportive and low-income housing development; and

WHEREAS, CHV will develop and operate on the Facility's campus at the site of the "G Building" a new building, named CAMBA Gardens Phase II ("CGII") containing low-income housing, and housing for the formerly homeless subject to review and approval by the New York City Department of Housing Preservation and Development ("NYCHPD") and such other lenders, investors, or government agencies as may be required by the financing and structure of the project;

WHEREAS, an affiliate of CHV recently completed the development of a similar project at the Facility at the site of the former "J" and "N Buildings," named CAMBA Gardens; and

WHEREAS, a Public Hearing was held on March 6, 2014, in accordance with the requirements of the Corporation's Enabling Act, and prior to execution, the sublease is subject to approval of the City Council and the Office of the Mayor.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be, and he hereby is, authorized to execute a 99-year sublease with CAMBA Housing Ventures, Inc. or with a not-for-profit housing development fund corporation in which CHV is the sole member, or with a limited partnership or limited liability company in which the general partner or managing member, as applicable, is an affiliate of CAMBA Housing Ventures, Inc. for the development of low-income housing, and housing for the formerly homeless on the site of the "G Building," a parcel of land on the campus of Kings County Hospital Center of approximately 97,000 square-feet at a fair market value rent established by appraisal prior to entry into the lease, which is currently anticipated to be not more than \$2.5 Million in total.

EXECUTIVE SUMMARY

SUBLEASE AGREEMENT KINGS COUNTY HOSPITAL CENTER CAMBA, INC. OR AFFILIATE

OVERVIEW:

The President seeks authorization from the Board of Directors to execute a sublease with CAMBA Housing Ventures, Inc. ("CHV") or a not-for profit housing development fund corporation in which CHV is the sole member, or a limited partnership or limited liability company in which the general partner or managing member, as applicable, is an affiliate of CAMBA Housing Ventures, Inc. ("CHV") for the development of low-income housing, and housing for the formerly homeless named CAMBA Gardens Phase II (CGII), on the campus of Kings County Hospital Center.

NEED/ PROGRAM:

CAMBA is one of Brooklyn's largest community based social service organizations with a budget of approximately \$73 million and a diverse staff of more than 1,300 employees. CAMBA's mission is to provide services which connect individuals and families with opportunities to enhance their quality of life. CAMBA serves more than 35,000 individuals and families a year in six core areas: Economic Development; Education and Youth Development; Family Support Services; HIV/AIDS and Health Related Services; Legal Services; and Housing Services and Development.

Since 1991, CAMBA has played a significant role in working with the City to address its housing crisis. Today this portfolio includes homelessness prevention, housing relocation, emergency and transitional housing, affordable permanent housing and supportive housing. CHV, an affiliate of CAMBA, was formed in 2005 for the express purpose of undertaking supportive and low-income housing development.

An affiliate of CHV recently completed its development of two new buildings, totaling approximately 180,000 square feet on the site of the former "J" and "N Buildings," at the Facility to provide 209 units of supportive and affordable permanent housing.

CGII will create affordable and sustainable housing, connect patients being discharged from inpatient care to stable housing and critical social services, provide tenants with access to healthcare, and generate revenue for area businesses. The aim will be to reduce homelessness among those adults and families who have the most chronic issues and are difficult to serve and house individuals who are in HHC facilities. By providing safe and permanent housing for homeless adults and families with severe mental illness, CGII will not only ease the costly demand on Medicaid, public shelter use and psychiatric treatment services, it also will help our most vulnerable residents live independently and interdependently in the community.

The project is expected to participate in the NYS Energy, Research and Development Authority (NYSERDA) Multi-Family Performance Program to be sustainable and transit-oriented and is designed to achieve a Leadership in Energy & Environmental Design (LEED) Gold rating and meet the Enterprise Green Communities/HPD criteria, the first comprehensive green building framework for

affordable housing. CGII will provide healthy indoor air quality that is critical for tenants with chronic illnesses and lower electricity bills for tenants and building operations. A roof-top solar panel system is expected to provide at least 50% of common areas' electricity needs.

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

SITE: 560 Winthrop Street
Borough of Brooklyn

**PARCEL
SIZE:** Approximately 97,000 square feet

CONSTRUCTION The proposed project will produce a building of 256,330 square feet with 293 housing units. The development budget will be approximately \$95 Million. The projected construction start date is July 2014 and the estimated completion date will be late fall 2016. The construction will proceed based on with plans and specifications prepared by the subtenant, subject to approval by the Corporation, such approval not to be unreasonably withheld. The subtenant shall be responsible for all costs associated with the development and operation of its housing program.

INITIAL TERM: Ninety-nine (99) years

RENT: Subtenant shall pay rent at the appraised fair market value determined prior to entry into to the lease which is currently anticipated to be not more than \$2.5 Million in total. The appraisal shall be an as is appraisal undertaken prior to the making of any improvements by subtenant.

UTILITIES: The cost for all utilities required for the premises will be the responsibility of the subtenant.

**MAINTENANCE/
REPAIRS:** Subtenant will be responsible for all structural and non-structural maintenance and repairs, as it pertains to the development of the proposed new construction of CGII within the G parcel boundaries, excluding Kings County Hospital utilities and infrastructure, which shall remain the sole obligation of Kings County Hospital Center, and which shall be reserved to KCHC pursuant to easements contained in the sublease.

**New York City
Health and Hospitals Corporation
Board of Directors**

**CAMBA Gardens Phase II
CAMBA Housing Ventures, Inc.**

March 20, 2014



About CAMBA, Inc.

- CAMBA's mission is to provide services which connect people with opportunities to enhance their quality of life.
- Founded in 1977 as a merchants' block association, CAMBA now serves over 45,000 individuals and families each year with a budget of approximately \$100 million and a diverse and dedicated staff of more than 1,400 employees and over 60 locations throughout NYC.
- CAMBA provides services through an integrated set of six program areas: Economic Development; Education and Youth Development; Family Support; Health; Housing; and Legal Services.
- CAMBA serves people with low incomes; people moving from welfare to work; persons who are homeless, at risk of homelessness or transitioning out of homelessness; persons living with or at risk of HIV/AIDS; immigrants and refugees; children and young adults; entrepreneurs and other groups working to become self-sufficient.
- In response to a pressing need for permanent, stable and affordable housing for Brooklyn residents, CAMBA, Inc. created an affiliated, non-profit affordable housing development corporation in 2005 named CAMBA Housing Ventures, Inc.

About CAMBA Housing Ventures, Inc.

- CAMBA Housing Ventures' (CHV) mission is to develop sustainable and energy efficient buildings that provide safe and affordable housing for low-income and formerly homeless families and individuals.
- CHV envisions vital neighborhoods where affordable housing and design excellence play a critical role in the long-term economic and social success of lower-income individuals and families.
- CHV developments provide sustainable and transit-oriented housing with services for formerly homeless individuals and families with special needs or low-income individuals and families from the community.

Production Summary:

- **Completed:** 605 units in Brooklyn, representing \$174 million in public/private investment.
- **In construction:** 175 units in Brooklyn representing \$60.5MM in public/private investment.
- **In predevelopment:** Approx. 746 units representing over \$255M in public/private investment.
- **In total:** CHV is 1,526 units (\$490MM) towards the goal of 1,000 units by 2015.

HHC Partnership for Supportive Housing

Within any given year, hundreds of patients experience extended stays in HHC hospitals or nursing homes due to lack of affordable, supportive housing

- **HHC/KCHC is a key partner in the creation of much needed supportive, affordable housing on underutilized hospital property**
- **Need for supportive, affordable housing:**
 - As of March 17, 2014, there are over 52,000 people living in NYC shelters: 22,495 children and 29,578 adults
- **NY State Comptroller's Affordability Report:**
 - In 2012, 53% of renter households in Brooklyn are paying above the affordability threshold (30% of income towards rent), up from 43% in 2000. 30% of Brooklyn households have a severe rent burden (paying more than 50% of income towards rent), up from 25% in 2000.
- **DOHMH recent report released on cost effectiveness of supportive housing:**
 - In two year study (2007-9), tenants in NY/NY III funded supportive housing had significant net savings in jail, shelter, State psychiatric facilities and Medicaid utilization; as compared to those not placed in NY/NY III housing.
 - \$10,100 savings of tax dollars per tenant; nearly 3,900 tenants placed during the study period

CAMBA Gardens Phase I and II Project Goals

- **Continue successful partnership with HHC and KCHC**
- **Continue successful model of CAMBA Gardens, co-locating housing and healthcare**
- **Maximize units to provide more affordable housing and units for HHC patients in the most efficient manner**
- **Build an attractive community asset and relate to Hospital, Residential areas & CAMBA Gardens Phase I**
- **Provide a variety of active and passive spaces for tenants of all ages**
- **Build sustainably to reduce energy bills and provide healthy indoor air quality for tenants**

Existing G Building



CAMBA Gardens Phase II Features

- **293 rental units: mix of studios, 1, 2 and 3 bedroom units**
- **Over 256,000 total square feet**
- **Amenities & services**
- **Landscape and green features**
- **Sustainable design**

CAMBA Gardens Phase II Units

Population	Studio: 320 ave. SF	1 bedroom: 550 ave. SF	2 bedroom: 780 ave. SF	3 bedroom 1,010 ave. SF	Total by Pop. Type
Community Units (60% AMI)	17	23	48	22	110
Formerly homeless/ Special needs	158 (incl. anticipated 50 KCHC/DSSM patients)	5	14	5	182
Super's unit	-----	-----	-----	1	1
TOTAL UNITS BY SIZE	175	28	62	28	293

- 182 or 62% Special needs units (includes anticipated 50 KCHC/DSSM units) with anticipated rental subsidy
- 110 or 38% Low-income, earning less than 60% AMI

CAMBA Gardens Phase I Lease-up

- 197 of 207 leases signed. Remaining 10 leases (3 low-income, 7 formerly homeless) to be signed within 1 week.
- Current HUD/HPD guidelines allowed for the following preferences as used on CAMBA Gardens Phase I (61 Community Units):
 - Current and eligible residents of Community Board 9 & 17: 31 units – ALL LEASED
 - Of 31 units leased, 4 units leased to KCHC employees
 - Eligible households that include persons with mobility impairments: 4 units – ALL LEASED
 - Eligible households that include persons with visual and/or hearing impairments: 2 units – ALL LEASED
 - Eligible King’s County Hospital Center employees: 10 units – ALL LEASED
 - **Exceeded goal by leasing 14 units to KCHC employees.**
 - Applicants who can document displacement by Hurricane Sandy and/or its related storms: 7 units: 5 LEASED; Winn secured waiver for 2 units to be moved to non-preference category, unable to be filled.
 - Eligible City of New York Municipal Employees: 4 units – 3 LEASED
 - Non preference units: 3 units - LEASED
- The current HUD/HPD preferences above are anticipated for CAMBA Gardens Phase II.

CAMBA Gardens Phase II Community Units Lease-up

- CAMBA Gardens Phase II will provide 110 units for low-income community households earning up to 60% of Area Median Income
 - 17 studios, 23 one-beds, 48 two-beds and 22 three-beds
 - CHV negotiated with HPD to allow for 17 community studios, based on CAB feedback.
- HPD supervised and required lottery
- The current HUD/HPD preferences used for CGI are anticipated for CAMBA Gardens Phase II (on prior slide).

2014 HUD Income & Rent Limits for Community Units

60% of Area Median Income (AMI)*

Apt. size	Maximum rent (tenant pays electric in addition)	Ave. Household size	Maximum income
Studio	\$833	1	\$35,280
1 bedroom	\$895	1.5	\$37,800
2 bedroom	\$1,082	3	\$45,360
3 bedroom	\$1,247	4.5	\$52,380

Please note:

1. The above rents and incomes are provided as reference, not the actual rents for CGII
2. *Area Median Income: Area refers NY/Northern NJ/Long Island Metropolitan Statistical Area
 - a. Includes all 5 boroughs and following counties: Westchester, Rockland, Putnam, Nassau, Suffolk
3. Rents and income limits are determined by HUD each year and change annually
4. Rents will be determined by actual income & household size

HUD 2014 Maximum Incomes by Household Size

Household size	Maximum income- 60% AMI
1	\$35,280
2	\$40,320
3	\$45,360
4	\$50,340
5	\$54,420
6	\$58,440

1. Income limits are determined by HUD each year and change annually
2. Rents will be determined by actual income & household size

CAMBA Gardens Phase I

Rendering:



Completed:



CAMBA Gardens Phase II Draft Design



Former Site G, Kings County Hospital Center

Draft Design: Dattner Architects

CAMBA Gardens Phase II Draft Design



Former Site G, Kings County Hospital Center

Draft Design: Dattner Architects

CAMBA Gardens Phase II Draft Design



Former Site G, Kings County Hospital Center

Draft Design: Dattner Architects

CAMBA Gardens Phase II: First floor and Landscape plan



CAMBA Gardens Phase II – Cellar plan



CAMBA Gardens Phase II Financing Model

Construction Financing:

- New York State Housing Finance Agency (HFA) tax exempt bonds
 - Credit enhancement provided by TD Bank
- Medicaid Redesign Team capital funds through HFA
- Low-Income Housing Tax Credits (LIHTC), syndicated by Enterprise Community Investment
- New York City Dept. of Housing Preservation and Development: Supportive Housing Loan Program (HPD)
- FY14 City Capital
- New York State Homeless Housing Assistance Program (HHAP)
- NYSERDA
- Supported by Council Member Mathieu Eugene & Brooklyn Borough President Marty Markowitz

Social Service Funding:

- New York City Department of Health and Mental Hygiene NY/NY III
- New York State Office of Mental Health NY/NY III

CAMBA Gardens Phase II

Next steps

