

BOARD OF DIRECTORS MEETING
THURSDAY, MARCH 22, 2012

A-G-E-N-D-A

<p>Call to Order - 4 pm</p>	<p>Dr. Stocker</p>
<p>1. Adoption of Minutes: February 29, 2012</p>	
<p><u>Chairman's Report</u></p>	<p>Dr. Stocker</p>
<p><u>President's Report</u></p>	<p>Mr. Aviles</p>
<p><u>Information Item</u></p>	
<p>➤Importance of 1115 Waiver to HHC – K. Raske, President, Greater New York Hospitals Association</p>	
<p>>>Action Items<<</p>	
<p><u><i>Generations+ / Northern Manhattan Network</i></u></p>	
<p>2. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable license agreement with Con Edison Company of New York, Inc. for use and occupancy of space for the operation of a radio communication system at Harlem Hospital Center. <i>(Capital Committee – 03/01/2012)</i></p>	<p>Ms. Youssouf</p>
<p><u><i>MetroPlus Health Plan, Inc.</i></u></p>	
<p>3. RESOLUTION authorizing the Executive Director of MetroPlus Health Plan, Inc., to negotiate and execute a contract with Healthplex, Inc., to provide administration of dental services for a term of three years (3) years with two (2) options to renew for one (1) year each, solely exercisable by MetroPlus, for an amount not to exceed \$4.9 million per year. <i>(MetroPlus Board – 03/13/2012)</i> <i>EEO: Approved / VENDEX: Pending</i></p>	<p>Mr. Rosen</p>
<p><u>Committee Reports</u></p>	
<p>➤Capital ➤Community Relations ➤Finance ➤Medical & Professional Affairs / Information Technology ➤Strategic Planning</p>	<p>Ms. Youssouf Mrs. Bolus Mr. Rosen Dr. Stocker Mrs. Bolus</p>
<p><u>Subsidiary Board Report</u></p>	
<p>➤MetroPlus Health Plan, Inc.</p>	<p>Mr. Rosen</p>
<p><u>Facility Governing Body / Executive Session</u></p>	
<p>➤Bellevue Hospital Center ➤Metropolitan Hospital Center</p>	
<p>>>Old Business<<</p>	
<p>>>New Business<<</p>	
<p>Adjournment</p>	<p>Dr. Stocker</p>

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (hereinafter the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 29th of February 2012 at 4:00 P.M. New York time, pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Dr. Michael A. Stocker
Mr. Alan D. Aviles
Josephine Bolus, R.N.
Dr. Jo Ivey Boufford
Mr. Robert Doar
Dr. Adam Karpati
Ms. Anna Kril
Rev. Diane E. Lacey
Mr. Robert F. Nolan
Mr. Bernard Rosen
Ms. Emily A. Youssouf

Andrea Cohen was in attendance representing Deputy Mayor Linda Gibbs, and Dr. Amanda Parsons was in attendance representing Commissioner Thomas Farley, each in a voting capacity. Dr. Stocker chaired the meeting and Jeremy Berman, Deputy Counsel designee to the Secretary to the Board, kept the minutes thereof.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on January 26, 2012 were presented to the Board. Then, on motion made by Dr. Stocker and duly seconded, the Board unanimously adopted the minutes.

RESOLVED, that the minutes of the meeting of the Board of Directors held on January 26, 2012, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

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

Dr. Stocker received the Board's approval to appoint two new committee members. Dr. Jo Ivey Boufford will serve as a member of the Audit Committee and Dr. Thomas Farley will serve as a member of the Medical and Professional Affairs/Information Technology Committee.

Dr. Stocker updated the Board on approved and pending Vendex and will report on the status of pending Vendex at the next Board meeting.

PRESIDENT'S REPORT

Mr. Aviles reported on his annual year in review for 2011 and the Corporation's monthly activities. Both remarks were in the Board package and made available on HHC's internet site. A copy of each is attached hereto and incorporated by reference.

ACTION ITEMS

RESOLUTION

2. Ratifying the actions of the Capital Committee of the Corporation's Board of Directors (the "Capital Committee") in approving work orders involving expenditures by the New York City Economic Development Corporation ("EDC") in connection with its management and design of the Goldwater North Project (the "Project") totaling \$246,777,768 and authorizing the Capital Committee to approval on behalf of the Corporation's Board of Directors future work orders for EDC on the Project.

Ms. Youssouf 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 negotiate and execute a management contract with **Johnson Controls, Inc.**, to manage the Corporation's **plant maintenance operations** for each HHC facility. The contract will be for a term of nine years in a total amount not to exceed \$363,191,470.

Joseph Quinones, Assistant Vice President, Contract Administration and Control explained that HHC is exposed to substantial rising costs in its plant maintenance operations, which includes the operation, repair and maintenance of HHC's facilities. A management contract is needed to control these rising costs and Johnson Controls was chosen through an RFP Selection Committee and was the highest rated proposer on both cost and quality. He further explained that the responsibilities of the vendor include hiring existing management staff to oversee HHC's plant maintenance services staff, training staff to improve performance, buying supplies and maintaining equipment. The anticipated savings resulting from the implementation of the Johnson Controls contract over a period of nine years are approximately \$127.9 million.

Mr. Rosen moved the adoption of the resolution which was duly seconded and adopted by the Board by a vote of 10 in favor with Rev. Lacey opposing and Mrs. Bolus and Ms. Kril abstaining.

RESOLUTION

4. Authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable **license agreement** with **T-Mobile Northeast, LLC**, for use and occupancy of space for the operation of a cellular communications system at **Coler/Goldwater Specialty Hospital and Nursing Facility, Coler Campus**.

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

RESOLUTION

5. Authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable **license agreement** with **T-Mobile Northeast, LLC**, for use and occupancy of space for the operation of a cellular communications system at **Coler/Goldwater Specialty Hospital and Nursing Facility, Goldwater Campus**.

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

RESOLUTION

6. Authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable **license agreement** with **Westat, Inc.**, for a parcel of land for siting trailers in which the Licensee will conduct a U.S. Centers for Disease Control national health survey on the campus of **Queens Hospital Center**.

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

RESOLUTION

7. Authorizing the President of the New York City Health and Hospitals Corporation to execute a **lease agreement** with **Dr. Mikail Kantius** for a space at 79-18 164th Street, Borough of Queens, to house the Women, Infant and Children Program (WIC) operated by **Queens Hospital Center**.

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

RESOLUTION

8. Authorizing the President of the New York City Health and Hospitals corporation to execute a revocable **license agreement** with the **Richmond County Medical Society and the Academy of Medicine** for use and occupancy of space to house administrative functions at **Sea View Hospital Rehabilitation Center and Home**.

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

BOARD COMMITTEE AND SUBSIDIARY BOARD REPORTS

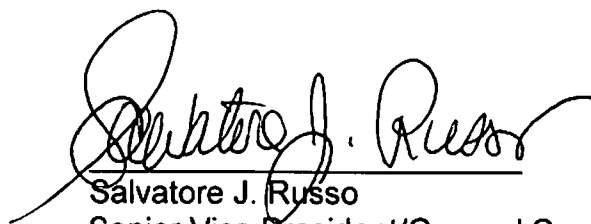
Attached hereto is a compilation of reports of the HHC Board Committees and Subsidiary Boards that have been convened since the last meeting of the Board of Directors. The reports were received by the Chairman at the Board meeting.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Stocker reported that the Board of Directors as the governing body of Sea View Hospital Rehabilitation Center and Home and Coney Island Hospital reviewed, discussed and adopted each of the facility's reports presented.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 5:50 P.M.

A handwritten signature in black ink, appearing to read "Salvatore J. Russo". The signature is written in a cursive style with a horizontal line underneath the name.

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

COMMITTEE REPORTS

Audit Committee – February 9, 2012 As reported by Ms. Emily Youssef

Ms. Youssef introduced the newest Audit Committee and Board Member Dr. Jo Ivey Buford who was President of HHC under Mayor Koch's second and third administration and currently President of the New York Academy of Medicine.

Ms. Youssef then stated that she has been hearing that some people are kind of pushing back and nervous about what Internal Audits is doing. She would like to reiterate the importance of Internal Audits in an organization. It is not that you did something wrong and you are going to jail. It is more, okay, this is something we think we can improve and this is how to improve it. In most organizations various staff members will come to internal audits to ask for help. She urged everybody on the staff to pass the word along that internal audit is their friend, not the enemy. She then turned to Mr. Telano and asked him to introduce his staff.

Mr. Telano stated that he wanted to take this opportunity to thank his staff because they are the ones who perform all the work. After each audit meeting, he receives some accolades from each of the members and he wanted to pass that on to his many staff members.

Ms. Youssef directed the audit staff by stating that the Audit Committee members are very, very impressed with the work all of them do and thanked them. She then asked Mr. Telano to begin his presentation.

Mr. Telano thanked Ms. Youssef and stated that he will be using the Internal Audits briefing document as a guide and will discuss each of the sections.

Mr. Telano began the presentation by stating that the first item to be discussed is going over the completed audits. The first one is an audit of vital records performed at Metropolitan Hospital. He asked the representatives from Metropolitan to come to the table.

Ms. Youssef asked them to introduce themselves. They did as follows: Patsy Jones, Associate Executive Director for Regulatory Affairs and Elizabeth Guzman, CFO.

Mr. Telano continued by stating that in his opinion this audit was the best example of the value-added approach that he has been pushing for throughout the organization. As Ms. Youssef stated earlier, this was an audit in which we believe has assisted the Corporation and Metropolitan Hospital in making their operations more efficient. Mr. Telano noted that the Metropolitan staff was very, very proactive in addressing the audit comments. They reacted immediately, sometimes by the end of the day, in correcting some of the inefficiencies that were noted. He said that he applauds them in assisting us in that manner.

Mr. Telano continued by stating that as the briefing states one of the issues found was regarding the software system being used to register deaths and births. This system is provided by the Department of Health. The administrator assigned to this system was terminated in 2009 and there were duplicate accounts and we found there was no password expiration. It was recommended to them that all of these items be changed and as mentioned, management corrected everything immediately. The other finding was regarding the biometric machines which are also provided by the Department of Health. They are basically used to certify the birth and death certificates. The software use is EVERS, it's a web-based software hooked up to their computer and they input all the information. The process is they put their thumb in the machine to certify that all the information is accurate and timely. The finding is that there were some machines unaccounted for. According to the Department of Health, there should be thirteen machines, when a physical count was conducted there were eight. According to Metropolitan records they have seven.

Mr. Telano continued with the next area which was that birth registrations were not being done timely. We found that they had not been entered in the system for a nine-day period. Once the staff was notified, they immediately updated everything. Mr. Telano stated that it's his understanding that births and death should be entered within five days. The other finding was that spontaneous termination of pregnancies, STOPS and induced termination were being reported inconsistently. It appeared that the staff did not understand the difference between them, therefore there were being reported differently. Also, these STOPS and ITOPS had to be reported to the Department of Health electronically by the end of February, but we found that they were being reported manually as in the past which did not meet DOH's requirements. Once again when management was notified, they took action.

Mr. Telano continued with the last finding which is about death registrations and the late requests for burial permits for four people who had expired during the review. The burial permits are supposed to be completed five days after death, but they were requested 58 to 190 days after date of death. DOH policy requires the completion of a burial permit within 72 hours of death which means that bodies were still in the morgue.

Mr. Telano asked Ms. Guzman if this was correct. She responded by stating that they were fetuses. Mr. Telano stated that he did not think so, that they were people that were injured.

Ms. Guzman stated that this process has been tightened. There is daily communication between the morgue and the office to make sure whatever the status of what's in the morgue is being managed in a timely fashion.

Ms. Youssouf asked Ms. Guzman if she thought the internal audit report was helpful. Ms. Guzman responded yes.

Dr. Stocker asked if there's a plan to make sure that things discovered in an audit, in an individual facility becomes a lesson for the whole organization that this should not have to be done for every facility.

Mr. Martin answered yes, that that's his responsibility and he will pass on the recommendations and findings at the Senior Vice Presidents' meeting.

Dr. Boufford stated that this strikes her as a policy and procedures updates and training issues and it speaks to the system-wide question and whether steps should be taken to lead the other facilities.

Ms. Guzman responded that she's not sure if that's their role, but would hope that that's the role of the Audit Committee and possibly the Corporate Office to manage. In terms of Metropolitan, Ms. Jones was designated as the point person. Ms. Jones meets with the departments on a regular basis to check in and see that everything is in place. Ms. Guzman feels confident that this process has improved all the requirements.

Ms. Youssouf stated that what the Audit Committee has asked for is "best practices", whenever an institution finds things and finds ways to correct it she believes is your responsibility.

Mr. Martin stated that that's his job.

Mrs. Bolus asked if the forms were electronic or paper. To which Mr. Martin responded that the transmission to the Department of Health is electronic.

Mrs. Bolus then asked if the others are all paper. Mr. Telano responded that the birth and death registrations are through the software EVERS.

Dr. Boufford asked if the death registrations are also electronic. Mr. Telano responded yes, everything is electronic.

Ms. Youssouf if there were any questions. There were none. She thanked them.

Mr. Telano continued with his presentation by stating that he will speak about two audits done at Coney Island Hospital; Purchasing and the Medical Surgical Inventory Warehouse. He asked the representatives of Coney Island Hospital to come up to the table.

Ms. Youssouf asked them to introduce themselves for the record. They introduced themselves as follows: Gary Imperato, Purchasing Director; Paul Pandolfini, CFO and Kevin Fehily, Associate Executive Director for Material Services.

Mr. Telano stated that the issues found in the Purchasing audit were the same issues found throughout the Corporation. The first one is the for-payment only Purchase orders in which the invoice is paid before the purchase order is completed. These types of transactions are permitted because of emergency purchases for patient care. However, they need to be properly authorized by the executive director or his/her designee. The other two findings that we find consistently are the splitting of purchase orders. In the past, before the new Operating Procedure was issued there was a \$5,000 threshold, if it was over \$5,000 it needed additional approvals. We looked for purchase orders under that threshold for the same vendor in a short period of time for a similar item. The third area, Mr. Telano continued that seems to be prevalent throughout the organization is the processing of returned goods and the crediting on subsequent invoices.

Ms. Youssouf asked if there are plans to tighten this issue.

Mr. Pandolfini responded that for-payment only situations, we do them all and signing off on them and analyzing how to prevent it going forward. Some of the situations arise when crossing over from one fiscal year to the next and that they are going to have to be more diligent in transitioning from one year to the next.

Mr. Imperato stated that as far as the split purchase orders are concerned, these are engineer and maintenance type orders, repairs and plumbing supplies for nonmedical. We started to move those purchases into contractors as these vendors did not have contracts. At this particular time they are being negotiated. There are other vendors that have contracts for those products. We are moving those purchases into those areas.

Dr. Stocker asked if they have seen the new procurement operating procedure. Mr. Imperato responded yes. Mr. Stocker ask him to comment on it. Mr. Imperato stated that it makes life a lot easier.

Mr. Imperato continued by stating that as far as the bidding practices is concerned we are now able to purchase up to \$25,000 for nonmedical, it actually streamlines the process. In as much as a bid takes a while, a written bid takes four to six weeks, sometimes longer, this will make life easier for the end user and put things in the proper place.

Dr. Stocker said that the idea was to make this workable but also follow the operating procedure.

Mrs. Bolus asked if the software detects if the end user has gone over the minimum amount?

Mr. Imperato responded that in the OTPS module there is a way to find out how many vendors are being used and how much has been spent and how the money is spent.

Ms. Youssouf asked if the system is able to keep track of the same vendors being used and how much they are getting.

Mr. Imperato responded that that was correct and we can look at the method of purchase and contract.

Mrs. Bolus asked if there a way to track when an item comes off warranty.

Mr. Imperato said that currently he does know of any software that does that. That it's up to the individual department to know when the warranty comes up.

Mrs. Bolus stated that was one of the problems, that in the past they were being presented with things that were past the warranty date and resulted in hasty purchases.

Dr. Stocker asked if all the contracts are being entered into GHX system now and does it track when they are going to expire. To which Mr. Imperato responded that the GHX system is much better than it was, there are a number of contracts that are active in there and are kept up to date. There are still some issues when things expire but it's much better than a year ago and that is due to the training the staff is getting in collaboration with Greater New York.

Dr. Stocker asked how comprehensive is it and are all the contracts that supposed to be on it are actually there.

Mr. Fehily responded that for all medical supplies and equipment, yes, and some household items. He does not think the engineering supplies have been moved yet, but that is the next step.

Mr. Telano continued by stating the other audit at Coney Island was a surprise count of the inventory medical/surgical area and the findings were that 81 percent of the items counted were incorrect. Noted also was that there were no security cameras around the stores. Warehouse management was not aware of all the individuals who have access to the inventory area and we found some items that were waiting for donation were left unattended and unsecured in the hallway. We also noted that when items were being distributed up to the units that there is some control weaknesses, no verification that the items being sent are the ones being ordered and there is no count being done to ensure that what the surgical unit ordered is the item received. The last finding had to do with the location of the warehouse. It's on the basement floor of the facility and because Coney Island is near or on the beach there is a lot of flooding. Air quality and the lighting are also very poor. The ceiling is low with exposed heating pipes. It just seems that some improvements need to be made within the physical warehouse.

Ms. Youssouf stated that this part raises some concerns. She asked if they have developed any kind of systematic plan or are in the process to actually address these items as far as some kind of inventory control, logging in, some form of accountability, proper counts as well as moving the storage area. Ms. Youssouf continued by saying that being close to a flood disaster puts the corporation in a very vulnerable position in terms of a lot of money being stored there in terms of product.

Mr. Pandolfini responded that in terms of controlling inventory, they have been reinforced through training and should be happening in the stores management area. Counts are done on a weekly basis. The counting department and assistant comptroller have put a program in place to do a shelf system count. There are still discrepancies and are in the process of examining what could be done to correct it. A lot of the discrepancies in counts are due to differences in the goods ordered and the way they are dispensing, for example a unit may be a case, but when dispensing it could be a bottle. In the absence of an automated inventory system, it is a fairly cumbersome manual process to keep track, but it has to be done. They are doing the best they can with the resources they have, they will continue to monitor this and improve it on a weekly basis by ongoing monitoring and feedback.

Ms. Youssouf asked if there was a best practice that another facility utilizes that perhaps would be helpful to share with Coney Island and she stated that the lack of controls is a big issue.

Mr. Martin responded that he did not know, but will certainly look to see and try to find out if there is some sort of best practice.

Ms. Youssouf added that if he could get back to them on that and also she said that she would very much like to encourage them to try to put together some kind of plan. That she knows it is difficult and that she appreciates it, but it is also incredibly important.

Dr. Boufford asked if there's a bar coding system and if that's a system that might be explored? To which Mr. Martin responded that that he thinks it's a great idea that he certainly thought of that too. But he would include that as well as anything else in terms of best practice.

Mr. Pandolfini added that as far as the camera placement goes, there is a hospital-wide project going on right now but for safety and security reasons. It's not completed but it includes the area that was audited.

Dr. Stocker asked that after going through the trouble of an audit, is there a way of instituting them into an operating procedure and that at least evaluating the possibility of that. To which Mr. Telano responded that he does not believe there is an OP on that. Mr. Stocker then stated that it seems like a way to institutionalize what is found and make it available.

Mr. Martin stated that there is an operating procedure in terms of filing a birth and death certificate.

Ms. Youssouf stated that again inventory control may be a bigger issue because there seems to be an issue with this elsewhere. She knows it's a big issue to deal with especially with the amount of inventory therefore she thinks the recommendation of the scanners, the bar code, is a great one.

Dr. Boufford stated that it's a capital project for the other side.

Ms. Youssouf stated that there must be a manual way to do something. Also she hopes that by the next Audit Committee they'll be a plan in place.

Mr. Telano added that the cycle counts they have done helps and it brings to light unit of measure issues that Mr. Pandolfini was saying. Four out of the 15 discrepancies found probably resulted because of unit measure issues.

Dr. Stocker stated that he just wanted to mention that the staff did a great job in evacuating the hospital during the storm.

Ms. Youssouf thanked them.

Mr. Telano continued stating that the next audit conducted at the Generations+ /Northern Manhattan Network is also about purchasing with the same findings.

Mr. Telano stated that the last item is the audit of the biomedical engineering function that occurred at Woodhull. Mr. Telano asked the representatives to come up to the table.

They introduced themselves as follows: Lisa Scott-McKenzie, Senior Associate Executive Director; Zaheer Baig, Comptroller and Mr. Corrales, Superintendent Buildings and Grounds.

Mr. Telano said that the objective of the review was to evaluate the controls of the management of the biomedical equipment. The equipment type is EKG's, ventilators and radiology. Overall, it was found that the record keeping of the database that they use needs some tightening up. For example, equipment that was relinquished still appeared to be active on the database. Work orders were not signed and reviewed by supervisory personnel. Biomedical engineering is not always notified when equipment is being moved, and there was no administrative oversight to the database system. Overall the recordkeeping being used needs to be corrected.

Ms. Youssouf asked to explain how this is being addressed.

Ms. Scott-McKenzie started by thanking Internal Audits for their friendship and their recommendations. The audit was conducted in a very professional manner and we found their suggestions to be very helpful. All the items identified have been corrected except for the equipment that is moved during emergencies. Some additional supervisory controls have been added for example, patient services, AOD and some of the ADNs will track the equipment the next morning after to be sure we know where those pieces are located. We are also looking into an asset tracking system or GPS type system for the equipment. Since sometimes the equipment is put away in closets, with this system we'll be able to track them.

Ms. Youssouf added that she thinks that is a brilliant idea and maybe something that can be best practice that others may do.

Mrs. Bolus added that some of the equipment has to be put in the closet or JCAHO will fine us for having equipment in the walkways. Ms. Scott-McKenzie stated that it does have to be moved from the aisle, but in our facility there are segregated areas where they should be placed and where we expect to find it.

Ms. Youssouf thanked them.

Mr. Telano stated that he has a couple of other audits in progress. Last week the affiliation audits were started with SUNY at Kings County. As a follow-up from last meeting, the auxiliary audit at East New York is being completed. The field work by the CPA firm for year 2011 will also be starting next week.

On the external audits, regarding Overtime, we received some communication from the State Comptroller's Office after them being silent since June of 2010. They wanted an update on financial information for calendar year 2010 and 2011 because the work was done on data from 2009. They advised me that this information would be background and will not result in any additional findings.

The last page is follow-up audits which you had requested to be included. Since the last meeting, we did a follow-up audit on Medicare Billing at Gouverneur and everything has been resolved. The other audit still outstanding on the schedule from December, is the follow-up of the Purchasing audit at Queens Network, we have a meeting with them next week on the 15th. We reached out to them in January to try to perform this review, but they were not available to meet with us until February 15th, so we are a little behind on that.

Ms. Youssouf thanked Mr. Telano and his staff for a thorough report and then turned the meeting over to Mr. McNulty for his report.

Mr. McNulty began by introducing himself to the Committee Members and started his presentation with an Office of Corporate Compliance (OCC) staffing update. Mr. McNulty stated that the last time the Audit Committee met the OCC had five (5) vacancies. He was pleased to announce that all those vacancies had been filled and commented that a number of exceptional individuals were recruited. It was pointed out that one individual is currently the inspector general for the Workers Compensation Board of New York State. Mr. McNulty added that this individual also had sixteen (16) years experience as a deputy chief in the criminal bureau of the U.S. Attorney's Office for the Eastern District of New York. Mr. McNulty also informed the Committee that two individuals were recruited internally. He stated that one is the Deputy Corporate Compliance Officer, James Saunders. Mr. McNulty noted that Mr. Saunders has over twenty (20) years experience with HHC, and that Mr. Saunders put in fifteen (15) or twenty (20) years at Bellevue and then at Central Office in the Office of Media Relations & Communications. He further added that Mr. Saunders was currently at Coney Island Hospital in the role of AED (Associate Executive Director) of facilities and communications. Mr. McNulty remarked that the other individual recruited internally was Ina Perlman. Mr. McNulty stated that Ms. Perlman was currently serving as HHC's deputy corporate risk manager. He stated that Ms. Perlman has years of experience at HHC and is a nurse by training. Mr. McNulty provided that the other recruited individuals included someone from the (NY) Attorney General's Medicaid Fraud Inspector Unit, and another who comes from the Island Peer Review Organization (IPRO).

Ms. Youssouf stated that that is great recruiting and that she is happy that all those positions are filled.

Mr. McNulty continued by moving along to the Deficit Reduction Act (DRA) Certification and the Department of Social Services (DSS) Mandatory Provider Certification. Mr. McNulty explained that the DRA certification, which is required by the Federal Government, mandates that HHC certify it has written policies and procedures related to fraud, waste and abuse, whistle blower policies and policies that prohibit retaliation. With regard to the DSS provider certification, Mr. McNulty explained that this certification provides that HHC has a mandatory compliance program in place and HHC has all the elements in place for such a program. He advised the Committee that Mr. Aviles certified in December, through the office of the Medicaid Inspector General, that HHC had met both the requirements for the DRA certification and the DSS mandatory provider compliance program certification.

Mr. McNulty then continued with the CY 2010 Corporate Compliance Workplan. He remarked that the CY 2010 Workplan had 17 items. He added that the OCC had completed eight (8) of these items and the remaining nine (9) items were near completion. Mr. McNulty continued noting that in CY 2011 the OCC added 40 additional items to the Workplan, which were listed in attachment number two, page 16. He explained that new items were in the assessment phase where a determination would be made as to whether or not there is a risk or vulnerability with respect to a particular item. It was pointed out that these items came from the following: (1) Office of Inspector General and the Office of Medicaid Inspector General's work plans; (2) fraud alerts received by HHC; and/or (3) internal audits of HHC-operated facilities conducted by regulatory bodies. Mr. McNulty informed the Committee that a web-based process procured last April, MediRegs, was used to help with the risk assessment process. He remarked that MediRegs was a very good product that has helped the OCC identify what the regulatory or the best practice standard was so that this standard can be met when the risk assessment are performed. Mr. McNulty provided that once the assessment cycle is finished the next step is the mitigation cycle. It was provided that once a risk or vulnerability is identified a plan of correction is determined and implemented by way of written policies and procedures and other internal control and practices. Mr. McNulty added that the next step in the process was the monitoring and auditing cycle. Additionally, where necessary items entered into a post cycle review phase - - thus where an item is closed and an effective plan of correction has been put forth but the item is reviewed once again in a year or two.

Mr. McNulty stated that he has been in talks with Mr. Chris Telano and his Office of Internal Audits to work jointly on the post cycle review phase to make sure that whatever plans or corrections in place were working. Mr. McNulty asked if there were any questions with respect to the Work plan.

Ms. Youssouf responded that this is very well organized and that the progress that has been made in his department since his takeover is equally as impressive as Internal Audits and that she is very pleased to see this.

Dr. Boufford asked if the group identifies possible vulnerability areas as well.

Mr. McNulty responded that the Office of the Inspector General for the Federal Government releases a general report that indicates the areas (of risk) that they look at. He added that the OCC then assesses whether or not HHC has vulnerabilities in these areas. The State Office of the Medicaid Inspector General releases a report six months thereafter and the OCC then updates its report (Workplan). It was noted that if any particular hospital facility has been audited by a regulatory body, the OCC communicates the same with HHC's Offices of the Inspector General, Internal Audits, and Legal Affairs.

Dr. Boufford asked if there is any communication with the Professional Affairs/Quality Committee, since the list includes hospital admission of undocumented immigrants and low birth weight.

Mr. McNulty stated that at first glance it looks like those items would be quality related, but the OIG is looking at whether or not HHC is following (CMS) conditions of participation.

Dr. Boufford added that she meant communication. To which Mr. McNulty responded that yes, in the agenda, on page four, item number V, it was agreed that a committee on compliance and quality would be established and it would meet with the chief medical officer and other members on a quarterly basis. This committee would look at Workplan items and determine whether a particular item should have oversight through the Audit Committee or the Quality Assurance Committee, or both under certain circumstances.

Dr. Boufford inquired whether item # 28 on the Workplan status update table (Human Research Subject Protection) was an IRB function.

Mr. McNulty responded that the Corporation has a human research protections administrator (HPA), who is required under HHC's terms of assurance with the Federal Government to enable HHC to perform research. He commented that the OCC was working jointly with the HPA further to develop HHC's human research protections program. It was noted that HHC has a research council chaired by Dr. Wilson, HHC's Chief Medical Officer; it was also noted that the OCC was working with this council and the HPA on strengthening HHC's written policies and procedures with respect to research compliance. Mr. McNulty then moved forward on the agenda to item number IV (Updating Written Policies and Procedures), which he explained involved taking a closer look at HHC's written policies and procedures with respect to billing practices and other practices mentioned in the 1998 Office of the Inspector General's (OIG) compliance guidance. Mr. McNulty stated that the OCC was also looking at OIG's their 2005 supplement to ensure that HHC's current practices are consistent with OIG's recommendations contained therein.

Mr. McNulty continued by stating that the OCC was looking at HHC's Principles of Professional Conduct. He added that although HHC has a good Principles of Professional Conduct (POPC) in place now that is distributed to its staff and a corresponding signed acknowledgment is obtained, the POPC would be further developed in the form of an operating procedure. He added that he anticipated completion of the subject operating procedure in a month or so.

Ms. Youssouf asked if it's signed upon employment or is it re-signed every few years. To which Mr. McNulty responded that it's signed one time upon employment, but that the same principles were part of HHC's annual training.

Ms. Youssouf asked Mr. McNulty to discuss item number VI on the agenda.

Mr. McNulty continued with the Network compliance activities. He explained that, where appropriate, individual compliance committees will be instituted at HHC's Diagnostic and Treatment Centers (D & TCs) and nursing facilities. Giving an example, he explained that in the Bronx, Segundo Ruiz Belvis and Morrisania D&TCs would have a joint committee meeting, but that individual meetings would also be conducted (at Renaissance). He commented that individual meetings are necessary to focus on compliance issues unique to these particular facilities. It was added that separate meetings would take place at Metropolitan and Harlem Hospital in CY 2012. Mr. McNulty then turned his attention to the last item on the report -- excluded providers. He remarked that there were no reports of self disclosures that occurred since the last Audit Committee meeting.

Capital Committee - February 9, 2012

As reported by Ms. Emily Youssouf

Assistant Vice President's Report

Alfonso Pistone, Assistant Vice President, Office of Facilities Development, advised that the meeting agenda contained five (5) action items and three (3) information items. The information items included an update of the Harlem Hospital Center Major Modernization project, an update on the progress of establishing parking arrangements at North General/Goldwater North, and a report by the Dormitory Authority of the State of New York (DASNY) on Minority and Women Business Enterprise (MWBE) statistics for the Harlem

Modernization project. He advised that there are no projects in delay greater than six months, and therefore there would be no project delay reports to provide.

Mr. Pistone informed Committee members, as a follow-up to an inquiry regarding the limits of HHC's responsibilities with respect to the eventual decommissioning of the existing power plant located on the campus of Coler-Goldwater Specialty Hospital and Nursing Facility, that the Office of Legal Affairs had contacted the City's Law Department for an opinion to establish limits of that responsibility. Mr. Pistone said he would continue to keep the Committee informed on the progress of the discussion.

This concluded the Assistant Vice President's Report.

Action Items:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with Westat, Inc. (the "Licensee"), for a parcel of land for siting trailers in which the Licensee will conduct a U.S. Centers for Disease Control national health survey on the campus of Queens Hospital Center (the "Facility").

Robert Rossdale, Deputy Executive Director, Queens Hospital Center read the resolution into the record on behalf of Ann Sullivan, MD, Senior Vice President, Queens Health Network. Mr. Rossdale was joined by Louis Iglhaut, Associate Executive Director, Queens Hospital Center, Dion Wilson, Assistant Director, Office of Facilities Development, and Omar Bordatto, Westat, Inc.

Mr. Rossdale provided some details on the agreement, noting that there are 8,000 square-feet of vacant land on the Queens Hospital Center campus where Westat, Inc. would be locating their trailers, after evening out the land, and that Westat will pay \$3,000 per month for approximately three and one half (3 1/2) months. In 2007, Westat had a similar agreement at Queens Hospital Center while they performed similar studies, which Mr. Rossdale explained went well. Mr. Rossdale noted that for the facility this agreement is a win-win.

Josephine Bolus, RN, asked about the retaining walls on a map of the site and whether those retaining walls were structurally sound. Mr. Iglhaut advised that both retaining walls are safe and are part of a brand new building.

Mrs. Bolus asked what would be located on another space located on the map. Mr. Iglhaut advised that a small, one-story, modular building would be constructed on that other site. Mrs. Bolus asked what that building would house. Mr. Iglhaut said it would hold office space for the facility, and is in no way related to the Westat agreement.

Mrs. Bolus asked about parking arrangements for Westat. Mr. Iglhaut stated that parking would be located within the boundaries indicated on the map.

Mrs. Bolus asked how many employees Westat would have on site. Mr. Bordatto advised that approximately 16 employees would be working there.

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

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

Authorizing the President of the New York City Health and Hospitals Corporation (the "Tenant" or the "Corporation") to execute a lease agreement with Dr. Mikail Kantius (the "Landlord") for space at 79-18 164th Street, Borough of Queens, to house the Women, Infants and Children Program (the "WIC Program") operated by Queens Hospital Center (the "Facility").

Robert Rossdale, Deputy Executive Director, Queens Hospital Center read the resolution into the record on behalf of Ann Sullivan, MD, Senior Vice President, Queens Health Network. Mr. Rossdale was joined by Louis Iglhaut, Associate Executive Director, Queens Hospital Center, Ophelia Rankine, Associate Director, Queens Hospital Center, and Dion Wilson, Assistant Director, Office of Facilities Development.

Mrs. Bolus noted an error in the executive summary where the three year term is written as a five year term. Mr. Wilson clarified by explaining that the initial term of the lease is three years, but there is a single five (5) year option to renew.

Mrs. Bolus asked why the lease agreement was with a single doctor and whether he would be staying in the space for the length of the term. Mr. Wilson advised that Dr. Kantius is the owner of the building and therefore the landlord. He also noted that the lease would contain language that would allow for HHC to remain in the space even if there were a new owner.

Ms. Youssouf asked if the building were sold and the new owner wished to demolish the building where would HHC stand. Jeremy Berman, Deputy Counsel, stated that lease would not be subordinate to any other agreement and that the sale of the building would be

subject to the lease. Ms. Youssef asked if that would be true for all eight (8) years of the lease or just the initial three year term. Mr. Berman advised that any rights that the tenant (HHC) has under the lease would be protected.

Ms. Youssef noted that a three (3) year initial term and five (5) year option seemed unusual. Ms. Rankine advised that the initial term was due to the fact that there are three years remaining on the Request for Application (RFA). Mrs. Bolus asked why there is then a five year option. Ms. Rankine advised that the New York State Department of Health had encouraged that. Alan Aviles, President, stated that as he understood it, RFAs are usually in five year terms, and so it appeared that the initial three year term would close out the current RFA and the five year extension would allow for another full term RFA if desired. Ms. Rankine confirmed.

Ms. Youssef asked if there was language in the lease stating that the RFA would have to be renewed in order to exercise the five year option. Mr. Wilson advised that the decision to renew would be up to HHC. Ms. Youssef stated that if the RFA is not renewed then the agreement should dissolve. Mr. Aviles advised that the option term is exclusive to the tenant, so it is entirely HHC's decision whether to use the option.

Ms. Youssef asked if the 2.5% escalation would continue during the five year option term. Mr. Wilson confirmed it would.

Mrs. Bolus asked if there were any known plans that the federal government would be making changes to WIC programs. Mr. Aviles said there were none that he was aware of.

Ms. Youssef asked how many patients are typically seen. Ms. Rankine advised that the caseload has been approximately 4,500 per month, with anticipated growth to about 5,000 per month as a result of the proposed increased space.

Mrs. Bolus asked if there was a WIC program located within the facility itself. Ms. Rankine advised that there was no on-site WIC program, but this location was very close to the facility. Antonio Martin, Executive Vice President, agreed, stating that the proposed site is just down the street, on the corner.

Mrs. Bolus again asked why the lease is with a single doctor instead of just being located on the campus. Mr. Wilson advised that the doctor (Landlord) is not affiliated with the hospital and the agreement is with that landlord.

Ms. Youssef asked what else is located in the building. Mr. Wilson said the landlord/doctor has an office on the upper floor. Ms. Youssef asked if he was a sole practitioner. Ms. Rankine responded by advising that the landlord runs a lab on the upper floor, and does not see patients.

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

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

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a revocable license agreement with T-Mobile Northeast, LLC, (the "Licensee"), for use and occupancy of space for the operation of a cellular communications system at Coler-Goldwater Specialty Hospital & Nursing Facility, Coler Campus (the "Facility"). Current agreement expires October 31, 2012.

Michael Buchholz, Senior Associate Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility, read the resolution into the record on behalf of Lynda Curtis, Senior Vice President, South Manhattan Health Network, who was present at the table. Mr. Buchholz and Ms. Curtis were joined by Dion Wilson, Assistant Director, Office of Facilities Development, Christopher Roberson, Director, Bellevue Hospital Center, Ronald Moore, T-Mobile Northeast, and Dave Collins, Pinnacle Telecomm.

Mr. Buchholz advised that T-Mobile occupies 200 square-feet of space at the facility and would continue to do so under this new agreement. The occupancy fee for the new agreement is \$52,840 per year, with annual increases of four percent (4%). The first year occupancy fee under the new agreement is a four percent increase over the current rate.

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

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

Authorizing a work order to increase the Economic Development Corporation's (EDC) work order threshold by thirty six million, five hundred thirty-five thousand, seven hundred and twenty-three dollars (\$36,535,723) to one hundred twenty eight million, four hundred forty thousand, seven hundred and seventy-nine dollars (\$128,440,779) for EDC to provide all architectural, engineering design services, pre-construction, construction, construction management and project management services necessary for the renovation of the former North General hospital building into a new Long Term Acute Care Hospital (LTACH) building.

Michael Buchholz, Senior Associate Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility, read the resolution into the record on behalf of Lynda Curtis, Senior Vice President, South Manhattan Health Network, who was present at the table. Mr. Buchholz and Ms. Curtis were joined by Marsha Powell, Director, and Dean Moskos, Director, Office of Facilities Development, Emil Martone, Dmitri Konon, and Zac Smith, of the New York City Economic Development Corporation (EDC).

Mr. Konon began by providing an overview of the history of the Goldwater North project, and its budget variances. He advised that the land acquisition costs had been moved to the LTACH budget from the Skilled Nursing Facility (SNF) budget, and proceeded to explain why the SNF project cost slightly decreased, while the LTACH project cost slightly increased. He noted that EDC became part of the project in late 2010, when they hired the design team of Array/Geddis and the construction management team of Gilbane/McKissack to work along with EDC and HHC in preparing estimates and furthering the project designs. Mr. Konon explained that the significant project cost increases were identified by three major categories. 1) *Due Diligence*: Estimates were not as thorough as necessary, which was a result of the rush in calendar 2010, prior to EDC's involvement in the project, to prepare project estimates and file the required Certificate of Need application with the New York State Department of Health. The subsequent due diligence conducted by EDC and its team resulted in the recognition of major changes with respect to mechanical systems in the existing building, as well as the need to conduct soil borings on the land where the SNF is being constructed. Mr. Konon noted that, in a typical project, if proper time is allotted, more discoveries are made and dealt with in concert with the design process, including information regarding ground conditions, or conditions within an existing building. It is not atypical that the design process changes based upon conditions revealed along the way, in which case estimates are adjusted. 2) *Change in Scope*: Mr. Konon explained that the bed count revisions and program revisions contributed to the change in project costs. 3) *Acceleration*: Mr. Konon noted that the project has been accelerated significantly in order to reach the target completion date of November 2013.

Elaborating on each of the three categories, Mr. Konon advised that to address the errors resulting from lack of due diligence, EDC and HHC - over the last year and a half, retained Turner Construction to estimate the project. Turner's estimates were almost identical to estimates provided by Gilbane/McKissack. The SNF estimates were off by a few hundred thousand dollars, and the LTACH estimates that Turner provided were slightly higher due to their concern over the condition of the mechanical systems. When due diligence was eventually performed on those mechanical systems, it was discovered that regular maintenance had been neglected and the systems were in much worse shape than originally thought. Additionally, the New York City (NYC) Office of Management and Budget (OMB) value engineered the project twice, once in early 2011 and once in late 2011, and both covered design and cost reviews. In the fall of 2011, Hunter Roberts and VJ Associates were brought in to provide additional estimates on the project, and OMB confirmed that estimates by Gilbane/McKissack were accurate. OMB reviewed the design and made suggestions, some of which the design team included. OMB also reviewed acceleration costs along with HHC, Gilbane, Hunter Roberts and VJ Associates to determine costs of acceleration. Acceleration costs, as derived through OMB review, amounted to approximately \$25 million for the project.

Some specific items that drove the cost up on the LTACH project were: that the original Certificate of Need (CON) did not include required clearances for the ventilator bed program, the most significant programmatic change in the project which resulted in increased demolition and construction work; it was determined that the Mechanical Electrical and Plumbing (MEP) systems required much more work than initially expected. Although they looked like they were maintained well, they in fact were in very poor condition, and while the maintenance team at North General made it sound as if the major systems were maintained, when investigated more fully, it was realized that the rehab work that would need was extensive.

Ms. Youssouf asked about whether the maintenance team at North General had shared records or reports with EDC/HHC and/or the rest of the team, documenting the maintenance work. Mr. Martone said no but they did provide copies of contracts with outside firms that were in place to provide maintenance work. Mrs. Bolus asked if there was any recourse for this type of situation. Mr. Pistone said no, this was done prior to HHCs acquisition.

Continuing, Mr. Konon acknowledged that various unanticipated parts of the project were not included in the original CON (2010), such as the work-around that was required as a result of the Institute of Family Health (IFH) being located on the first floor of the building. The work around added cost to the project because with the IFH still located in the space, demolition would have to be completed around them.

Ms. Youssouf asked if HHC looked into alternative locations for the IFH. Mr. Konon advised that a significant amount of time was spent looking for alternate space, but the space and the cost differential was not significant, and the IFH expressed concern with moving. He explained that IFH would be moving to their new location on 119th Street and Madison Avenue. IFH did not want to move twice for fear patients would have trouble locating them. Between the cost and location issues, no alternatives were found. Ms. Youssouf asked if the cost would be completely absorbed by HHC, and Mr. Konon said yes. Capital costs for doing the work out of sequence would be absorbed in the capital cost of the project.

Also not included in the original CON were a significant amount of soft costs for insurance bonds, attorney fees, special testing, site remediation, environmental surveying, and permitting costs. The soft costs equaled a significant amount that was not originally included but are required items, and therefore had to be added. Mr. Konon noted that it was difficult to determine whether those soft costs had

been included in the original CON, possibly included in the hard costs. Ms. Youssouf asked if that was an oversight. Mr. Pistone said no, that at the time, with the information everyone had, the assumptions seemed reasonable. There was limited information.

More factors not included in the original CON were work on the elevators, roof and façade. At the time of the initial estimates, all three systems appeared to be in good condition, but it was not known that significant rehab would be needed for the elevators. Mr. Konon noted that both the roof and façade both leak. These, he advised, are conditions that were not identified because of the speed of the estimate and the lack of due diligence.

Ms. Youssouf asked that the following resolution, for the authorization of an EDC work order to increase the threshold for the SNF building be read into the record so that both work orders could be addressed together.

Authorizing a work order to increase the Economic Development Corporation's (EDC) work order threshold by one hundred seven million, five hundred thirty-six thousand, nine hundred eighty-nine dollars (\$107,536,989) to one hundred eighteen million, three hundred thirty-six thousand, nine hundred eighty-nine dollars (\$118,336,989) for EDC to provide all architectural, engineering design services, pre-construction, construction, construction management and project management services necessary for the construction of a New Skilled Nursing Facility (SNF) in the parking lot of the former North General hospital building.

Before continuing the discussion Ms. Youssouf asked for clarification on the dollar amount of the work orders. She asked whether the new approval level would be \$128 million for the LTACH and \$118 million for the SNF. Mr. Pistone confirmed.

Returning to his project overview, Mr. Konon advised that comparable costs on the SNF construction were in line with two similar projects, a Veterans Affairs (VA) medical center, where hard construction costs for a skilled nursing facility located in New York, New York were quite similar, and a nursing facility in Long Island where the cost was slightly lower, the variance likely resulting simply from the added expense of constructing on a contained site in New York City rather than an open site on Long Island.

Mr. Konon stated that with regards to the SNF project the variances are a result of the same three major areas, due diligence (which HHC was unable to perform before the original CON was filed), scope changes, and acceleration.

Mrs. Bolus asked why, if the SNF is being constructed on vacant land, was due diligence not performed. Mr. Konon explained that soil borings needed to be performed and there was not enough time in the early stages of the project to complete that work, as well as environmental testing, which is also a several month process. Both were eventually completed during the Spring/Summer 2011, but it took several months to get firms on board, perform the testing and review the results.

Mrs. Bolus asked whether it would not have been better to provide that information before, possibly including a stipulation in the preliminary budget that stated that full investigation had not been completed. Mr. Aviles advised that EDC was not on the project at that time, so it was HHC who did not provide that information.

Ms. Youssouf asked whether HHC had environmental firms on contract that could perform the type of work necessary, noting that it may not have taken such a great amount of time if they were on contract and ready to perform. Mr. Pistone said that HHC did not have firms on contract that could perform that extensive type of work necessary. Ms. Youssouf asked whether soil borings could not have been performed with a firm on contract. Mr. Pistone said no, the type of work that needed to be performed had to do with sub-surface conditions. Mr. Konon confirmed and said even to mobilize a "when and where" contract, which EDC does have with Environmental firms, the soil boring contractors would most likely be sub-contracted, and the process would have remained at a 2-6 month duration from start to finish. He advised that even if a firm is on contract, the sub-contractor still must go through the City's Vendex and procurement processes. Mr. Pistone stated that while HHC does have environmental firms under requirements contracts, they typically perform asbestos removal/remediation, and not the type of work that needed to be done on this site.

Mr. Konon again stated that EDC does have that type of contractor available, but it still takes time because mobilization of different contractors takes time.

Michael Stocker, MD, stated that there were a lot of compromises when this project was initiated, and decisions were being made in an intense political environment, but acknowledged that the general intent is a good one, and it is a great opportunity for HHC. He then asked about contingency fees, noting that EDC had approximately \$32 million in contingency fees on the budget. He asked for an explanation.

Mr. Konon advised that it was based on hard construction costs only, the design contingency for both the LTACH and the SNF would be 10% each, and 15% each for construction. It is currently approximately 11.3% on the total project budget, which includes soft costs. He stated that with design at approximately 50% complete, the contingency will likely be reduced in the future, either to be used for scope changes or for unforeseen conditions. As construction packages are procured (60-70 for the total project) if there are variances the contingency would go up or down, depending. At the end of procurement and design process, the remaining contingency would possibly

be folded into construction contingency. At some point, around summer 2012, the money could be released or used somewhere. He stated that some projects carry higher contingencies so the contingency (20%) for renovations EDC is using is not too large.

Dr. Stocker asked about the land acquisition cost that had been mentioned earlier, and what that represented. That if HHC did not in fact purchase the building or the land. Mr. Buchholz advised that early in the project, in order to save cost, it was briefly considered whether or not to build the new SNF on the Coler campus on Roosevelt Island, so that funding was placed in the hospital budget to ensure that it would be available. When it was determined that the facility could not be built on the Coler campus, the new CON was completed for the new construction on the lot adjacent to the existing North General location.

Ms. Youssouf requested that EDC come back at the March 1, 2012, meeting and provide a current budget with a breakdown of what had been spent on what, and where the money was going. She stated that she understood that the project is on a tight schedule and in order to move the project forward the work orders would need to be approved, but she wanted to continue the sharing of information and be kept up to date and in the loop with regard to the project, the budget, and spent-to-date information.

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

On motion by the Chair, the Committee approved the work order with the understanding that EDC would return at the March 1, 2012, Capital Committee meeting to present a thorough outline of the project budget and spending to date.

Information Items:

Due to time constraints it was determined that the Harlem Hospital Center Major Modernization Status Report, Goldwater North Parking Update, and the DASNY Report on MWBE Statistics would be postponed until the March 1, 2012, Capital Committee meeting.

In response to an inquiry from Committee members at the January 12, 2012, Capital Committee meeting concerning *Coler-Goldwater's transitioning planning for skilled nursing facility (SNF) residents*, LaRay Brown, Senior Vice President, was asked to provide a brief report on that subject.

Ms. Brown reported that one critical aspect of the transition of Goldwater's operations from Roosevelt Island to the new Goldwater North campus was the discharge of a number of current SNF residents who could benefit from home and community-based care. She noted that there were 371 individuals who have been assessed by Coler-Goldwater staff to be candidates for non-institutional based, or community-based, long term care. Of that number, 217 (58%) were under the age of 65 and more than 87% require some kind of mobility device. For example, she explained, 189 individuals require a wheelchair. Ms. Youssouf asked whether the residents would need supportive housing. Ms. Brown responded that many would not require supportive housing, which is defined as housing that entails on-site staff who provide services such as care coordination, meals, homemaker services, 24/7 oversight, etc. Ms. Brown went on to say that some individuals would benefit from supportive housing and she provided the example of 39 of the 371 individuals having been identified as having a serious mental illness diagnosis.

Ms. Brown continued her presentation by describing the various strategies and collaborations being pursued to obtain housing and other community resources for Coler-Goldwater residents. Specifically, she mentioned that staff has been working with the State Department of Health's Division of Long Term Care Services to enroll eligible Coler-Goldwater SNF residents into the Nursing Home Transition Demonstration program (NHTD). Participation in the NHTD program would enable individuals to access a range of support services as well as housing subsidies which can facilitate their transition from institutional settings to the community. The organization designated by SDOH to conduct assessments of candidates for the NHTD program has been working with HHC staff. Ms. Brown noted that approximately fifty (50) Coler-Goldwater SNF residents may be eligible for this program.

Ms. Youssouf asked if the NHTD program provides housing subsidies. Ms. Brown responded in the affirmative.

Mrs. Bolus asked whether the housing subsidy was Section 8, or dependent upon Social Security income. Ms. Brown responded that an individual's income (including Social Security benefits) was included in the eligibility determination for a housing subsidy. Of the 371 individuals, 291 have Social Security; others are likely eligible and obtaining this benefit is being pursued. Ms. Bolus asked why some individuals would not have Social Security. Ms. Brown responded that some individuals who are less than 65 years old may not be eligible or some may have refused to participate in the application process. She noted that there are a variety of reasons.

Ms. Brown advised that another important aspect of the discharge transition is the development of housing on an empty parcel of land on the campus of Metropolitan Hospital Center. That parcel is located at 99th Street and 2nd Avenue. HHC is working with an experienced housing developer, the Housing Preservation Development (HPD) and the New York City Housing Authority (NYCHA) to build 171 apartments, a mix of one-bedrooms and studios. She noted that these apartments will be slightly larger than what is typically designed by HPD for supportive housing, because not only are these units being designed to accommodate wheelchairs, but also because there is the possibility that some of the tenants will at some point in their community tenure, require home care services. Ms. Brown advised that financing will be provided through a combination of bond and tax credit financing, as well as grant funds. Ms. Brown

noted that the State has also committed funding towards this project. Importantly, project-based Section 8 subsidy is required for these 171 units. Ms. Brown reported that the developer had recently received a letter of commitment for such from NYCHA.

Ms. Youssouf asked if 9% tax credit financing was being used. Ms. Brown responded in the affirmative.

Ms. Brown explained that 171 apartments will be considered supportive housing units. She went on to say that Metropolitan Hospital Center and HHC's Home Health agency will provide services to individuals who will reside at the 99th Street development. She noted that proximity to Metropolitan Hospital was an extremely important benefit for the tenants and not having to build service space in the building allowed for more apartments.

Ms. Brown stated that the 99th Street project and the NHTD program would address the housing needs of only some of the 371 individuals. Hence, HHC staff has been in discussions with other housing providers throughout the City concerning the availability of housing opportunities for the remaining individuals. Housing subsidies are needed for these individuals as well; and this is being discussed with NYCHA.

Ms. Youssouf asked whether these individuals would be bypassing the list of people already on the list for section 8 housing. Ms. Brown responded that this was, in fact, the dilemma.

Ms. Youssouf asked about veterans. Ms. Brown responded that a veterans housing subsidy program is available and that HHC staff has initiated discussions with the Veterans Administration.

Ms. Brown concluded her report stating that she and her staff conduct monthly calls with the State Department of Health regarding these discharge efforts. Some individuals are proving to be a challenge and HHC will continue to engage the state in assisting Coler-Goldwater in ensuring that the most appropriate transition of SNF residents occurs.

Ms. Youssouf stated that she appreciated the update, and would be looking forward to more as the process moves ahead, and that she understood the difficulty. Ms. Brown said she is aware of the level of public scrutiny that will take place regarding the placement of these individuals, and advised that HHC is working with consumer organizations and others. She added that unions have been kept apprised of the discharge process plans for Goldwater.

- *Harlem Hospital Center – Major Modernization – Status Report (deferred)*
 - *Goldwater North – Parking Update (deferred)*
 - *DASNY Report on MWBE Statistics (deferred)*
 - *Project Status Reports*
 - North Bronx Health Network
 - South Manhattan Health Network
 - Southern Brooklyn/Staten Island Health Network
- * Network contains project(s) that require a delay report

As stated in Mr. Pistone's AVP report, there were no projects in delay by six (6) months or more and therefore no reports to provide.

Finance Committee – February 7, 2012
As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Zurack informed the Committee that her report would be deferred until later in the agenda in order to accommodate the action item.

Action Item

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a management contract with Johnson Controls, Inc. ("JC Inc") to manage the Corporation's plant maintenance operations for each HHC facility. The contract will be for a term of nine years in a total amount not to exceed \$363,191,470.

Mr. Martin after reading the resolution informed the Committee that a presentation, which was included in the package, would be presented by Mr. Quinones, Senior Assistant Vice President, Contract Administration and Control.

Mr. Quinones stated that several representatives, Paul Morgan, Stephen Herbst, Bob Giro, Glen Zilligan, Chris Howard, Stephen Terrano, Carol Skotnicki, and Jayme Hamann from Johnson Control, Inc. (JCI) were in attendance to address questions from the Committee. Beginning with the presentation, Mr. Quinones, in addressing the question of why there is a need for a vendor to manage plant maintenance, stated that HHC is currently exposed to substantial rising costs in its Plant Maintenance which includes operations,

repair and maintenance of HHC's facilities. As part of the Corporation's objective for achieving savings, the Restructuring Leadership Committee identified Plant Maintenance as one of the 39 projects included in that area. In order to control and standardize costs throughout the enterprise, a management contract is needed in order to control rising costs through the deployment of an experienced vendor. Failure to take action would result in HHC having to allocate limited resources from patient care to cover increased cost in non-core goods and services. In order to identify a skilled and experienced vendor, a request for proposals (RFP) was issued in accordance with HHC's operating procedures. The RFP selection Committee as part of that process chose Johnson Controls, Inc (JCI) as the highest rated proposer on both cost and quality. The proposed contract with Johnson Control will include multiple guarantees over nine years that will negate HHC's exposure to those projected rising costs.

In terms of the contractor's background, Mr. Quinones stated that Johnson Controls, Inc was founded in 1885. The Building Efficiency Division was established to address the need for a specialized, high quality, innovative and responsive Plant Maintenance Company, which services over 3,500 healthcare customers in the US and Canada, including over a dozen acute-care hospitals where full service plant maintenance is provided. JCI has a presence in more than 40% of North American healthcare facilities; 15,000 employees maintaining 17,000 building, 1.5 billion square feet across 90 countries with a client retention rate of 90%. JCI has earned the following distinctions: Top 100 Best Managed Companies, *"Industry Week,"* Top 100 Best Corporate Citizens, *"Business Ethics Magazine,"* Ranked #2 greenest Company, *"Newsweek,"* Corporate Diversity Award, World Diversity Leadership Council.

Mr. Quinones stated that JCI currently has contracts with the following entities: Department of Defense and Department of Energy, Hanford; Camp LeJune, NC; County governments: Fulton County, GA, Washington County, WI; Los Angeles County, CA. Healthcare facilities: Phoenix Children's Hospital; Methodist La Bonheur Healthcare, Memphis, TN; McGill Hospital, Montreal, ON; Abbotsford Hospital and Cancer Centre, Abbotsford, BC; Niagara Health System, St. Catharines, ON; Bridgepoint Health Centre, Toronto, ON; North Bay Regional Health Centre, North Bay, ON. JCI currently employs approximately 7,500 union employees represented by 56 collective bargaining units nation-wide.

Mrs. Bolus asked if HHC employees are represented by the same unions.

Mr. Quinones deferred the question to one of JCI representatives to which a response that those unions are the same was given.

Dr. Stocker asked JCI for further clarification.

Mr. Herbst stated that Locals 30, 637 and electricians unions are just a few. The 7,500 employees are NY employees that are within the unions.

Mr. Quinones continuing with the presentation stated that JCI has contracts with New York State and New York City agencies that include the HHC whereby JCI has performed maintenance, repair, refurbishment work in virtually all HHC facilities over the past ten years; Empire State Building, JCI currently performing a \$50 million energy performance contract that includes a retrofit program that will reduce the Empire State Building's energy use by 38% per year, placing it in the top 10% of all US office buildings in terms of energy efficiency; CUNY and DASNY/NYS OGS.

Mr. Quinones stated that JCI's responsibilities will include the hiring of existing management staff to oversee HHC's plant maintenance services staff; train staff to improve performance; buy supplies out of the contract payments at optimal cost; provide software for repair and maintenance work order tracking; provide necessary repair and maintenance tools; deploy the best methods across the enterprise to improve satisfaction; control personal services, overtime and OTPS costs; maintain equipment deemed to have exceeded useful life. A summary of the total savings by the various contract categories, fees, OTPS, management salaries, personal services, overtime and fringes is shown on page 8. For the purpose of the Committee, the box below that summary reflected a breakdown of the costs for the total value of the contract amount as stated in the resolution. Additionally the expenses that are non JCI expenses, Group 12 wage expenses and Group 12 benefit expenses are also reflected in that box.

Ms. Youssouf asked for further clarification of the services JCI will provide as part of Plant Maintenance.

Mr. Quinones asked Mr. Alfonso Pistone, Assistant Vice President, Facilities Development who oversees facilities plant operations to respond.

Mr. Pistone stated that the services that JCI will be providing would be the routine day-to-day operations, maintenance and minor repairs to keep the facilities functioning.

Mrs. Bolus asked if management would become a part of JCI and Group 12 employees would continue to be employed by HHC. Mr. Martin replied in the affirmative.

Mr. Quinones stated on page 9, a breakdown of the annual proposed savings each year was delineated by the previous cited categories, fees, overtime, management wages, fringes, PS and OTPS. The projected savings total \$127.92 million. On page 10, the

inflationary exposure for HHC over the nine-year term of the contract includes a major increase in fringe benefits estimated at 44.06% in FY 13 to 58% in FY 21; PS inflation factor in the current Financial Plan is zero salary increases for years 1-3 and 1.25% for years 4-9; Group 12 costs are estimated to be \$636.36 million for an average cost of \$70.7 million per year and OTPS costs are estimated at \$158.08 million for an average cost of \$17.56 million per year based on an inflation factor of 3%; total OTPS for routine plant maintenance costs are projected to increase to \$299.9 million or an average cost of \$33.32 per year. If HHC continues to operate at the current level of operations for plant maintenance, PS and OTPS costs are projected to escalate to approximately \$1.5 billion. Page 11 outlines how contracting with JCI will mitigate HHC's exposure over the nine-year term; Group 12 PS costs are capped at \$553.03 million compared to projected costs of \$636.36 million; overtime costs are capped at \$137.39 million compared to projected \$158.08 million; OTPS costs are capped at \$271.74 million compared to projected costs of \$299.94 million.

Mrs. Bolus asked if the unions have agreed to those caps and whether those caps are included in the contract that will be signed by HHC.

Mr. Quinones stated those were the expenses of HHC not the contractor.

Mr. Aviles added that the PS costs include the projected attrition that will reduce the headcount by 131 FTEs.

Mr. Quinones continuing with the presentation, page 12 reflected the total projected saving over the nine-year term of the contract which will be achieved by a reduction in the current projected operational costs of \$1.5 billion compared to the proposed contracting of the management services to JCI for a total projected saving of \$127.9 million, \$1.37 billion compared to \$1.5 billion, over the nine-year terms of the contract.

Ms. Youssouf asked for clarification of how the projected savings would be achieved.

Mr. Rosen asked if the savings would be attributable to the capping of the costs.

Mr. Quinones stated that it would be directly related to the caps as part of the guarantees that are reflected on page 8 of the presentation.

Ms. Youssouf asked if those were guarantees on behalf of JCI regardless of any unforeseen cost increases.

Mr. Quinones stated that the only change would be if there is a change in the scope of work.

Mrs. Bolus asked for an example of a change in the scope of work that would impact the cost. Mr. Quinones stated that if HHC were to acquire another facility.

Mr. Aviles added that conversely, if HHC closes a facility there would be reduction in the cost.

Ms. Youssouf asked how labor agreements would impact the cost.

Mr. Quinones replied that collective bargaining agreements which would be outside of JCI's control would increase the costs if the projections fall below the actual contractual agreement increases. Moving back to the savings on page 12, Mr. Quinones stated that the saving with JCI would be \$127.9 million over nine years at an annual average saving of \$14.2 million per year. The current estimated salary increases are projected to remain at the current level for years 1-3, increasing by 1.25% for years 4-9. Costs related to OTPS, PS and overtime are guaranteed.

Ms. Youssouf asked if HHC's managers would be moving over to JCI and the Group 12 employees would remain with HHC and whether the savings would be achieved by JCI through better management of HHC's plant maintenance operations.

Mr. Quinones, concluding the presentation, stated that some of the added benefits of contracting with JCI included: union employees will not be terminated as a consequence of outsourcing Plant Maintenance Operations; current management employees will have the opportunity to become employees of JCI; a corporate-wide Life Cycle Assessment will be performed cataloguing and evaluating infrastructure equipment; standardization of work order tracking would be implemented to monitor costs and productivity.

Mrs. Bolus asked if the management employees would have an option to go with JCI or remain with HHC.

Mr. Aviles stated that it is not an option but that those employees could seek other employment opportunities within HHC but could not remain with HHC in their current role as part of Plant Maintenance. This option is consistent with all other outsourcing of management service contracts, such as environmental services and Brooklyn central laundry, whereby some employees opted not to take the option being employed by the contractor and secured positions in the private sector.

Mrs. Bolus asked how often the Board would be informed of the status of the implementation of the Life Cycle Assessment.

Mr. Aviles stated that it would be as often as the Board would require that report.

Dr. Stocker asked if annually would be sufficient for the Board to receive a status report. The Committee was in agreement with having an annual report.

Ms. Cohen asked if there were any structural difference with that model in comparison to the Crothall contract for environmental services or whether it is fundamentally the same model. Mr. Martin stated that it is the same.

Mrs. Bolus asked if HHC would be the largest system managed by JCI and whether that would be a major challenge.

Mr. Herbst stated that HHC would be one of the largest healthcare contracts for JCI; however, it is not dissimilar to other contracts managed by JCI in the private sector that are global in nature. JCI will take best practices and technologies from those implementations and apply them to the HHC.

Mrs. Bolus asked what the estimated response time is given that HHC facilities are spread throughout the five boroughs.

Mr. Herbst stated it is difficult to make that assessment at this time given that one of the priorities for improving efficiencies is to group similar types of work orders or responses so that JCI will not service the same piece of equipment more than once for multiple service requirements. JCI will make an assessment of all equipment and operational function and the response time will be tailored to that criticality and will work with HHC to ensure that the appropriate interpretation of that criticality.

Mrs. Bolus asked how JCI would maintain equipment that has been determined to have exceeded useful life.

Mr. Herbst stated that HHC is currently maintaining that function; therefore, JCI would continue to monitor all equipment in conjunction with HHC.

Mr. Pistone added that HHC has in its capital plan a replacement program of its infrastructure. There is some flexibility within the capital plan to address issues that are identified by JCI as they may relate to the life cycle assessment that will be undertaken.

Mrs. Bolus asked if there will be a manager assigned to each facility to oversee the daily operations.

Mr. Herbst stated that there will be a manager assigned to each facility, consistent with HHC's network structure for the leadership of the facilities for plant maintenance and operations and HHC's operating procedures. JCI's enterprise-wide platform will be made available to HHC.

Ms. Youssouf asked if there are incentives or standards included in the contract by which HHC will monitor JCI's performance and whether there are any penalties attached to those performances if JCI fails to achieve those standards.

Mr. Pistone stated that there are no performance incentives included in the contract; however, the contract will include provisions that will allow HHC to extricate from the contract if performances are not satisfactory.

Ms. Youssouf asked if there would be penalties included as part of those provisions.

Mr. Quinones stated that if JCI does not perform to HHC's standard, the contractor will not receive payment. There are no penalties included in the contract.

Mr. Rosen asked if HHC or JCI would bear the cost if the estimates included in the personal services costs are greater than projected.

Mr. Quinones stated that HHC would bear those costs. Mr. Rosen added that those costs would include fringes, overtime, salaries, etc. Mr. Quinones stated that those costs would be included.

Mr. Aviles added that it is important to note that in terms of HHC's current situation, if there is an increase in cost due to collective bargaining agreements (CB), HHC would bear those costs. However, through this process there will be savings through attrition.

Ms. Youssouf asked if attrition would apply also to management.

Mr. Aviles stated that it only applies to Group 12.

Mrs. Bolus asked if the CB contracts would remain with HHC or JCI. Mr. Aviles stated that HHC will maintain control of that process.

Mr. Rosen asked where JCI's NY office is located. Mr. Herbst stated that JCI is located at 60 East 42nd Street.

Mrs. Bolus asked if the replacement of the managers would be done by JCI as part of the agreement.

Mr. Herbst stated that the management team from HHC will be transferred to JCI and to the extent that there is a need to supplement those staff, JCI will hire externally and internally within the City.

Mr. Martin stated that it is to HHC's benefit that the managers are kept at the facilities. The intent is to ensure that the current managers are rolled-over to JCI and continue to manage the daily operations of those facilities.

Mrs. Bolus asked where would the replacements for those managers who over the nine year period retire or move onto other jobs.

Mr. Herbst stated that it is JCI practice to first look from within the organizational workforce for opportunities to advance the existing staff in other areas. The overall objective is to recruit staff with various levels of experience in order to enhance the standard of work.

Mrs. Bolus asked if JCI would be providing continuing education to assist staff in advancing to the next management level.

Mr. Herbst stated that JCI will not have any management control for the Group 12 employees; therefore, HHC would be in a better position to respond.

Mr. Martin stated that there will be continuing education to ensure that the Group 12 employees have an opportunity to advance through the organization.

Ms. Youssouf asked how many managers would be transferred to JCI and whether the contract is for those managers. Mr. Quinones stated that there are thirty one HHC managers.

Mr. Aviles asked if the thirty one managers was the total number included in the contract.

Mr. Quinones stated that there are thirty one managers for HHC and a total of forty five managers are included in the contract.

Ms. Zurack added that similar to the Crothall contract, the OTPS purchases will be made by JCI on behalf of HHC for a total of \$271 million which is the bulk of the contract. Contractors such as JCI are able to get larger discounts as part of their volume business.

Ms. Cohen asked why there are no performance based compensations included in the contract and whether JCI has this type feature included in other similar contracts.

Mr. Pistone stated there are no performance based incentives included in the contract due to JCI's expertise in this area; therefore, it was decided that it was not necessary to incentivize for that purpose.

Ms. Cohen asked if that was typical for other similar JCI contracts.

Mr. Herbst stated that it varies in that there are contracts that include performance incentives that include a balance score card, whereby there is equal opportunity for both penalty and reward depending on performance measures that are quantified. Oftentimes those types of incentives are implemented in the out years in order to have a better understanding of the baseline and how to measure performance which is probably one of the reasons HHC has opted not to include any in the initial work.

Ms. Cohen asked what some of the metrics are.

Mr. Herbst stated that some would include response time, health and safety measures, recordable incident, time loss, and quality standards that are somewhat difficult to measure are based on surveys and are more subjective.

Ms. Youssouf asked if JCI would have a system in place to track the amount of time it takes to complete work orders and efficiencies.

Mr. Herbst stated as part of JCI's technology that feature would be included.

Ms. Youssouf asked if it would be monitored by HHC. Mr. Pistone stated HHC would be responsible for monitoring that performance.

Mr. Rosen asked if any of the JCI representatives would be assigned to the NY office.

Mr. Herbst stated that he is based in Chicago, but that three of the representatives in attendance would be assigned to the NY office.

Mr. Rosen asked if those three JCI representatives would be the point of contact for HHC.

Mr. Herbst stated that they would be in addition to the staff that will be transferred from HHC to JCI.

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

Senior Vice President's Report

Ms. Zurack stated that her report would include an update on two items. First, currently HHC's cash on hand (COH) is at 27 days compared to 35 days last month. However, it is anticipated that COH will return to 35 days by year-end. There are a number of pending supplemental Medicaid payments that are extremely important in maintaining a healthy cash balance. At the State level, last year the State passed a two-year Medicaid budget, this being the second year that included a freeze, an inflation factor and a 2% cut. In terms of the Governor's budget, there minimal impact to HHC. There were some new initiatives that were funded related to the MRT workgroup and some changes in benefits. Some of the items in terms of the service mix include, podiatry for adult diabetics was added, breastfeeding support and tobacco support, while knee orthoscopic, back pain treatment, angioplasty and growth hormones were cut in certain situations. The old State proposal remains a factor whereby there was a reduction in payments for elective C-sections that were without medical indications; however, the details of that action are currently under review after deferring this issue another year. In addition \$32 million was added to address health disparities for expanded services translation reimbursement data collection; \$100 million for vital access providers and essential community providers who were referenced in the MRT.

Ms. Cohen added that those did not affect HHC.

Ms. Zurack stated that although there no impact to HHC, it is important to provide the Committee with some of the highlights of the State Budget. There is \$25 million to modernize and automate the Medicaid eligibility system and \$1.5 million to promote the expansion of non-physicians. Those investments will be funded by a proposal that has been repeatedly discussed, the elimination of the spousal refusal; redirection of the expiring acute care transition funding and the elimination of some of the previous cited benefits. Those are some of the highlights that as previously stated will have a minimal impact on HHC but a greater impact on some patients in Brooklyn.

Key Indicators/Cash Receipts & Disbursements Reports

Mr. Fred Covino reported that on Page 1 which shows utilization year-to-date through December 2011, acute discharges are down by 4.9% which is consistent with last month; however, it is a significant improvement from 9% at the beginning of the year. The Diagnostic and Treatment centers (D&TC) visits are down by 6.7%, however, this is a significant improvement compared to 10.7% in July 2011. Nursing home days are down by 4.7% which has remained at that level throughout the year. The ALOS, the majority of the facilities with the exception of Lincoln are within a 1/3 day of the corporate average, whereas Lincoln is at 1/2 day below that average. The CMI is up by 1% compared to last year for the same period which is on top of a 6% and 4.5% for the last two years. Pages 2, FTEs are down by 137 since June 2011 which is 168 FTEs less than the target for the year-to-date (YTD) period. The FTE level is down by 747 compared to the last year. In the last twelve months, FTEs were reduced by 750. Through December 2011, receipts are \$42.6 million better than budget while disbursements are \$23 million less than budget resulting in a net total of \$65 million against the budget. Page 3, a comparison of cash receipts and disbursements to the current and prior year actuals, receipts are \$397 million worse than last year due to the timing of DSH and UPL payments. In FY 10, a large payment of \$727 million was received in December but was not this year for the same period. Expenses are \$86 million worse than last year due to payments to the City that are \$144 million higher this year, in addition to the timing of those payments that are offset by a reduction in personal services (PS) of \$23 million and a reduction of \$54 million. Overall receipts are \$484 million worse than last year. Page 4, a comparison of the actuals against the budget through December 2011, receipts are up by \$19.2 million due to an increase in Medicare collections which are up due to the timing of the PIP reduction. Outpatient collections are up by \$13.2 million due to a large increase in Medicaid managed care disbursements due to a retro rate adjustment from MetroPlus of \$27 million for ER and Amb Surgery rates for calendar year 2011. All other is up by \$10 million due to an increase in appeals and settlements that are higher than anticipated in the budget. PS expenses are \$3.4 million worse than budget due to overtime spending and OTPS is \$22.7 million better than planned due to a rollover from last year into the current year.

Mr. Aviles informed the Committee that a three-month hiring freeze had been imposed through April 2011. There are some exceptions, one being IT services.

Mrs. Bolus asked if RNs are exempted. Mr. Aviles stated that RNs are not automatically exempted; however, there is an opportunity to appeal to the Chief Operating Officer, Mr. Martin for extraordinary needs.

Ms. Cohen asked what a PIP payment is. Ms. Zurack stated that it is a Periodic Interim Payment, whereby, Medicaid pays a steady cash flow and adjusts when actual claims are adjudicated.

Mr. Migdal added that HHC is probably one of the last systems in the industry that receives those payments.

Information Items:*Inpatient, Outpatient Adult and Pediatrics Payor Mix Reports*

Ms. Maxine Katz stated that the Inpatient Payor Mix report from July 2011 through December 2011 shows that there is a slight improvement this year in the percentage of insured to the total. In almost all of the payor categories with the exception of commercial managed care and commercial, all other payors are down this year compared to last year. However, there is also a decrease in total discharges by 4,000. There is a slight shift in the payor mix but there is also a decrease in discharges and self-pay discharges as well. The outpatient adult payor mix report comparing the two years, the trend has remained steady at the same level. However, there are some shifts in the outpatient payor mix. Self-pay is down in addition to other payor categories. Total visits and patient volume is also down. Pediatrics payor mix is also holding steady at the same rate comparing the two years but total patients and visits are down and there is also a shift in payor mix.

Mr. Rosen commented that the percentage of insured to total remains at the same level. Ms. Katz stated that it is but that self-pay is down while the payor mix appears to be shifting into different categories. Over the years, Medicaid fee for service was higher but is now migrating to other payors. There is more commercial and commercial managed care than in prior years.

Inpatient Medicaid Eligibility Report

Ms. Katz reported that the Medicaid applications submitted are down and overall eligible decisions are down from year to year; however, the percentage of eligible decisions to applications submitted are better than last year. Requests for additional information from HRA are down compared to last year.

Mrs. Bolus asked what contributed to that improvement.

Ms. Katz stated that a number of Breakthrough activities centered on Medicaid applications have taken place. The facilities have implemented operational changes and are monitoring the application process more closely; more training is being done for the staff based on the ineligible decisions that are being returned. HHC has been working very closely with HRA on training staff and working to improve the front-end processes that involve contacting the patient immediately after a determination has been made that the patient will be admitted. Overall better practices have been implemented but more improvements are needed. One of the key factors in these process changes is that the facilities are very active in the process by making site visits to other facilities to examine best practices and deciding which works best for their facility.

Mr. Rosen asked when the State is expected to take over Medicaid and whether that would mean that the function will shift from HRA to the State. Ms. Zurack stated that it is not known at this time.

Ms. Cohen added that it is unclear at this time exactly what the process will be.

**Medical & Professional Affairs / Information Technology Committee –
January 26, 2012 – As reported by Dr. Michael Stocker**

Chief Medical Officer Report:

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

Employee Flu Campaign

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

CMS Health Care Innovation Challenge

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

Regional Perinatal Centers (RPC)

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

Sexual Assault Response Teams (SART)

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

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

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

Prevention of Alcohol Exposed Pregnancies (AEP)

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

Hurricane Irene - Federal Emergency Management Agency (FEMA) Application

The HHC Office of Emergency Management submitted a Corporate Application totaling approximately \$4 million to FEMA to obtain reimbursement expenses incurred for Hurricane Irene. Expenses include mitigation, overtime staff, supplies, equipment for all HHC facilities and for the Special Medical Needs Shelters.

MetroPlus Health Plan, Inc.

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

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

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

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

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

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

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

- Improve the referral relationships with key providers so that they will refer potentially interested members to our marketing team. A focused provider education campaign is currently underway;
- Establish a partnership with key City agencies and CBOs delivering services to our target population, with the goal of enhancing our community outreach efforts and increasing our presence in the community;
- Develop a member-centered media campaign targeting prospective members and care givers and/or opinion leaders within our target population through channels such as outdoors media (including subway), newspapers, and radio.

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

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

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

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

Chief Information Officer Report:

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

IT Governance Update

A year ago, Mr. Robles reported to this Committee on the restructuring of the IT Governance process and the creation of the IT Executive and IT Portfolio Management Committees. Both these committees are comprised of Executive and Senior Leadership across the Corporation and are charged with decision making authority and accountability with regards to IT investments. Mr. Robles provided a brief update on the status of each committee's work in the past 12 months as follows:

- The IT Portfolio Management Committee's (ITPMC) focus this past year has been to balance HHC's overall IT needs and priorities. The membership is comprised of operational leadership from the networks and Health & Home Care. The committee meets monthly and their charge has been to identify clinical and business issues requiring IT solutions, monitor those IT investments already underway and providing recommendations to the IT Executive Committee. They have been diligent in reviewing and validating project requests from the networks, asking the right questions and making the hard decisions of what gets funded or not. Committee members take their charge seriously and the group has coalesced into a governing body who's mandate is an "Enterprise first perspective" instead of a "Network first perspective" when reviewing IT project requests.
- The IT Executive Committee meets bi-monthly and its membership is made up of all the Senior Vice Presidents including our Executive Vice President and President. This committee's charge is to establish IT strategies and policies approve project investments and provide the necessary balance for multiple stakeholder needs. Over the past year, this committee has concentrated their energies in fully reviewing and supporting both those critical IT project investments underway as well as the key IT strategic initiatives moving forward. Committee members continuously assess and question information provided to them in order to make the most effect IT decisions. This committee remains focused on ensuring that IT decisions support HHC's business strategy.

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

Windows 7 Project Update

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

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

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

Information Items:

Women's Health Measures

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

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

Health Home Update

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

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

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

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

Medicaid eligible individuals must have: 1) two chronic conditions 2) one chronic condition and are at risk for a second chronic condition; or 3) one serious persistent mental health condition, in order to qualify for health home services. The list of conditions include: mental health condition; substance abuse disorder; asthma; diabetes; and heart disease. Other chronic conditions covered include HIV/AIDS and hypertension.

There are three tiers of complexity of the recipients that HHC will receive: 100,000 at the moderate level; 24,000 at the multiple/complex level; and 5,000 at the intense level, based on our model and 2010 data.

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

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

Strategic Planning Committee – February 7, 2012
As reported by Josephine Bolus, RN

Senior Vice President Remarks

Ms. LaRay Brown greeted and informed the Committee that her remarks would include brief updates on federal and city issues and the Corporation's Breakthrough initiative. Ms. Brown noted that key components of the Governor's 2012 - 2013 Executive Budget proposal which are important to HHC would be discussed during the information item presentation.

FEDERAL UPDATE

Ms. Brown reported that, on December 23, 2012, both Houses of Congress had passed by unanimous consent, a compromise bill that would extend for two months the Social Security payroll tax holiday, emergency unemployment insurance benefits and the current Medicare physician payments rates fix. Without an extension, there would be a 27.4% cut to Medicare physician payments. Ms. Brown informed the Committee that Congress had re-convened from its holiday break but would only have three weeks to agree on legislation to extend the payroll tax reduction and the Medicare physician pay rate fix for the remainder of the year.

Ms. Brown reported that the House-Senate Conference Committee had been working on a final bill. The hospital advocacy community's main focus is to ensure that the offsets do not include significant hospital provider cuts. Ms. Brown announced that two New York State representatives, Congress members Nan Hayworth and Tom Reed, would be participating in the Conference Committee. Notwithstanding, Ms. Brown emphasized that the "pay-for" provisions that had been included in the House's original bill (H.R. 3630) were being seriously considered by the Conference Committee. These provisions include onerous hospital provider payment reductions which would greatly impact HHC. Specifically, these reductions would:

- Significantly reduce payments for certain hospital outpatient (evaluation and management) services. This could reduce HHC's Medicare revenues by \$187 million over 10 years;
- Extend the Medicaid Disproportionate Share Hospital (DSH) reductions mandated by the Accountable Care Act (ACA) by one year, to 2021. This extension could cost HHC \$421.8 million in lost revenue for that year alone; and
- Reduce the allowable reimbursement for Medicare bad debt payments from 70 percent to 55 percent, costing HHC an estimated \$5 million over 10 years.

Ms. Brown informed the Committee that the hospital cuts that had been included in the bill totaled more than \$17 billion nation-wide. The hospital advocacy community, spearheaded by the American Hospital Association, is pushing to have the "pay-for's" for the Medicare Doctor Fix come from unspent funds that had been originally set aside to pay for the winding down of the Iraq and Afghan wars. In particular, New York State's Congressman Joseph Crowley has spearheaded a bipartisan letter emphasizing the need to use the unspent war funds, in order to negate the need for any hospital cuts.

Ms. Brown reported that, on January 13, 2012, the Center for Medicare and Medicaid Services (CMS) had issued a proposed rule that expanded the definition of "uninsured" in the Medicaid Disproportionate Share Hospital (DSH) program. Accordingly, DSH allocations can now include provider costs for persons whose health coverage does not cover a particular procedure for which there is no liable third party or for whom an annual lifetime cap would apply. Ms. Brown explained that, in 2008, CMS had excluded the cost of all services provided to a patient with any form of "creditable coverage" when CMS implemented the DSH audit requirements of the Medicare Modernization Act of 2003. This new rule would reverse the CMS rule that was implemented in 2008.

Ms. Brown further noted that the proposed rule would allow hospitals to increase their hospital specific DSH caps. While HHC supports this policy change, its implementation would not necessarily translate into additional revenue for HHC because New York State's current DSH allocations are not expected to increase.

CITY UPDATE

Mayor Releases FY 2013 Preliminary Budget

Ms. Brown reported that, on February 2, 2012, Mayor Bloomberg released the City's FY 2013 Preliminary Budget. The \$68.7 billion financial plan closes the budget gap for FY 2013 but a \$3 billion gap exists for FY 2014 and in the out-years. Because of these forecasted gaps, the financial plan includes agency spending reduction plans (known as PEGs for Program to Eliminate the Gap) that will save \$470 million this current Fiscal Year (2012) and \$1.02 billion in FY 13. Ms. Brown noted that HHC had received a 6% PEG to the City Tax Levy portion of its budget, which equates to a \$4.2 million reduction. This PEG will be achieved through a reduction in the subsidy that the City provides HHC.

Ms. Brown informed the Committee that the City Council would begin to hold hearings on the Preliminary Budget beginning in March. A second round of budget hearings on the Mayor's Executive Budget will occur in late May and early June.

BREAKTHROUGH UPDATE

Ms. Brown provided the Committee with an update on the Corporate Breakthrough Initiative on behalf of her colleague Joanna Omi, HHC's Senior Vice President for Organizational Innovation and Effectiveness. She reported that, as of December 31, 2011, more than 840 rapid improvement events in more than 80 value streams (52 of which are currently active) had been conducted throughout the Corporation. More than 11,000 employees have participated in Breakthrough activities. Ms. Brown noted that these figures were cumulative since the start of Breakthrough activity in November 2007; and the participant count included duplicates.

Ms. Brown reported that the Breakthrough training team had continued to conduct Lean certification and non-certification classes. As of January 6, 2012, a total of 534 HHC employees were certified at the Green Level, 154 at the Bronze level, and 24 at the Silver level. Two HHC staff achieved Gold level certification. There are 12 additional staff members who are working on the experience requirements for Gold certification. Ms. Brown added that a total of 378 employees had taken the Process Owner course (i.e., a non-certification course). She announced that the Breakthrough Office was planning to launch the first Platinum class in February. A Blue class for managers and Leadership training would be launched later in 2012.

Information Item

2012-2013 State Fiscal Year Executive Budget Overview

Ms. Brown introduced Wendy Saunders, Assistant Vice President and John Jurenko, Senior Assistant Vice President for the Office of Intergovernmental Relations. Ms. Brown informed the Committee that Ms. Saunders would be presenting an overview of key components of Governor Cuomo's 2012-2013 Executive Budget proposal that are critical to HHC.

Ms. Saunders reported that Governor Cuomo had released his 2012-13 Executive Budget proposal on January 17, 2012, which closed a \$2 billion budget deficit. Originally, the deficit was projected to be \$3.5 billion but was later reduced to \$2 billion as a result of actions taken by the administration in December 2011, relating to the millionaires tax. Ms. Saunders described key components of the Governor's Executive Budget proposal there were important to HHC. These components include:

A second year of a two-year agreement on Medicaid

- An increase in overall spending in Medicaid by 4% (as per last year's agreement)
- No new significant Medicaid cuts. Ms. Saunders reminded the Committee that there would still be an impact on HHC from the actions that had been taken last year. These actions include a no inflation factor for providers and a 2% across the board rate cut. The total impact of these actions on HHC is \$174.5 million. Ms. Saunders noted that there would be additional reductions due to the implementation of a new nursing home reimbursement system. The impact of this new system is not reflected in the \$174.5 million reduction.
- Creation of a New York State specific Health Benefits Exchange to implement the federal Affordable Care Act (ACA). This Legislation was passed by the Assembly but not the Senate last year.
- New authority for the State Department of Health (SDOH) to close health care facilities, replace operators or board members in circumstances where there are repeat violations, significant mismanagement or criminal activity. This recommendation came out of the recommendations of the Medicaid Redesign Taskforce (MRT) Health Systems Redesign: Brooklyn Work Group led by Stephen Berger.
- A cap on executive compensation of \$199,000. Ms. Saunders highlighted that, two days after the Executive Budget proposal was released, Governor Cuomo instituted this rule via executive order. This rule is now law in New York State.
- The phase-in of State takeover of the growth in the local share of Medicaid spending. Ms. Saunders explained that the increases in Medicaid spending that localities would have to pay had been capped at 3%. Going forward, this cap will be reduced to 2% in calendar year 2013 and then to 1% in 2014. In 2015, localities would not be responsible for any additional growth in Medicaid spending. This action is expected to save localities approximately \$1 billion over a five year period.
- Replacement of the 2012 nursing home bed hold provision with new rules for adult residents to be issued by SDOH. Ms. Saunders explained that a new rule will be promulgated by the State Commissioner of Health that would reduce funding for bed hold reimbursements to nursing homes by \$40 million. Ms. Saunders explained that there had been a similar provision that was enacted as part of last year's budget, which did not receive approval from the Centers for Medicare and Medicaid Services (CMS). Ms. Saunders added that, after the new rule is promulgated, the impact on HHC would be determined.

Andrea Cohen, representing Deputy Mayor Linda Gibbs in a voting capacity, asked for further clarification on what is meant by bed hold. Ms. Saunders responded that when a nursing home resident has to go a hospital, the nursing home receives payment to keep the bed open to allow for that patient to return to that nursing facility. She added that there will be a funding cut of \$40 million for adult patients. While nursing homes will still receive bed hold reimbursement, this reimbursement will be reduced. Ms. Brown explained that SDOH wants to encourage nursing homes to provide much more assertive health care services in the nursing home setting. This would lessen the need for patients to be hospitalized in an acute care setting for conditions that could have been better managed. It provides a greater sense of the need to ensure that patients can be kept as long as possible in the nursing home for their physical condition. The challenge will be to ensure that the many vulnerable and frail nursing home patients in need of acute care attention can get this attention as soon as it is needed.

- A requirement that managed long term care plans must offer consumer directed personal care as an option for their members.
- New electronic reporting of Health Care Reform Act (HCRA) cash receipts assessment. Ms. Saunders explained that facilities will now have to report that information electronically.
- An extension of the potentially preventable readmissions cut until 2013. It also allows SDOH to implement an adverse events policy in outpatient settings. Ms. Saunders reminded the Committee that this cut does not include behavioral health services.
 - An extension of the Global Cap on Medicaid spending for one additional year (three years total)
 - A 4.2% increase in Medicaid spending for next year 2013-14, which is consistent with the ten year rolling average of the Consumer Price Index (CPI).
 - Continuation of SDOH's "superpowers" if spending exceeds projections. Ms. Saunders reminded the Committee that this provision would allow the Commissioner to reduce payments rates or eliminate benefits to keep spending under the cap. Ms. Saunders reported that through November 2011, spending had remained on target and was at \$4.4 million below projection. Additionally, enrollment increases must be covered under the Global Cap. For the current fiscal year, Medicaid enrollment grew by nearly 2% or by 94,000 individuals.

Ms. Saunders informed the Committee that the Governor's Executive Budget proposal also included many of the recommendations that were made by the Medicaid Redesign Team (MRT). She reported that, on February 3, 2012, Jason Helgeson, the State's Medicaid director stated that the final MRT report was not due until the end of the fiscal year or March 31, 2012. Additionally, all of the recommendations made by the MRT would be included in the MRT report. Ms. Saunders informed the Committee that the MRT recommendations that were included in the Governor's Executive Budget proposal were cost neutral from the perspective of the new benefits that were added and those that were eliminated.

The MRT recommendations that were included in the Executive Budget proposal included:

- New benefits for Medicaid patients:
 - Harm reduction activities
 - Coordinated Hepatitis C care
 - Expanded maternal and child health services
 - Lactation consultants
 - Tobacco cessation counseling by dentists
 - Podiatry care for diabetes in private offices
 - Enteral formula for HIV patients (this was eliminated in 2012)
- Elimination of Medicaid benefits that were found to have no positive outcomes for patients as recommended by the MRT Benefits Review Committee. They are:
 - Arthroscopy of the knee for osteoarthritis
 - Treatments for lower back pain where there is no evidence for benefit
 - Percutaneous Coronary Intervention (PCI) or angioplasty in circumstance of no clear benefit
 - Treatment of Idiopathic Short Stature (ISS) with growth hormone
 - Reduced payments for elective C-sections and inductions < 39 weeks without medical indication
- Creation of a new supportive housing reinvestment program to help increase the availability of supportive housing. Ms. Saunders noted that the Budget proposes to continue a \$75 million investment that the State made last year for affordable housing
- New requirement for language accessible prescriptions for individuals who are limited English proficient or hearing impaired
- Expansion of data collection for disparities
- Targeted increase in funding to make fair hearings more accessible to support the move to mandatory enrollment in managed long term care
- A new Primary Care Service Corps to provide loan repayment for non physician primary care practitioners
- Enrollment assistance for Medicaid long term care patients through facilitated enrollers. This model has been used successfully in non long term care settings

- Electronic asset verification for certain Medicaid patients
- Phase-in of State takeover of Medicaid administration. Ms. Saunders explained that SDOH is proposing to conduct a gradual takeover that would be phased in over several years (the number of years not specified). Activities that would be assumed by SDOH include the processing of applications, eligibility determinations and the authorization of benefits. It was discussed that SDOH may contract with localities. This provision also includes the absorption of some local staff that may be displaced by the shifting of these functions to the state.
- Support for Medicaid rate enhancements for Essential Community Providers/Vital Access Providers under HEAL 21 by eliminating Inpatient Reform Transition II funding. Ms. Saunders informed the Committee that this recommendation originated from the Payment Reform MRT Subcommittee. She announced that a new HEAL NY 21 Request for Applications (RFA) had been announced that would provide \$450 million for capital improvements and rate enhancements.
- Closure of the Kingsboro Psychiatric Facility. Ms. Bolus inquired if the entire facility would be closed completely. Ms. Brown clarified that the State Office of Mental Health had stated that the current crisis residence programs would remain open but the inpatient facility along with the state operated facilities would close. Additionally, post acute psychiatric care would be directed to South Beach or Rockland. Ms. Saunders added that the State anticipates receiving HEAL NY 21 funding requests from providers within the vicinity of Kingsboro to increase their capacity. Ms. Brown informed the Committee that HHC's Coney Island Hospital was preparing a proposal to obtain CPEP funding. Additionally, Coney Island Hospital is also seeking funding to renovate its psychiatric emergency room. This would help to offset the potential impact of the closure of Kingsboro.
- Consolidation of New York City's Children's Psychiatric Centers. Mr. Nolan, Committee Member, asked if more specific information about the consolidation of the New York City centers was available. Ms. Saunders responded that the information provided included a list of all centers with general language regarding consolidation. Ms. Saunders added that she expected to learn more about the consolidation following the Legislature's budget hearings on health care and behavioral health.
- Extension of the Comprehensive Psychiatric Emergency Program (CPEP) for four years until 2016
- A new framework for SDOH and SOMH to jointly operate Behavioral Health Agencies with broad authority that would allow these agencies to waive requirements and deem compliance. Ms. Cohen asked for further clarification on this provision. Ms. Brown explained that the aim of this provision was not only to facilitate the integration of physical and behavioral health services in one setting but also to reduce the bureaucratic processes in dealing with the varied regulatory standards and licensing requirements of these agencies.

Ms. Saunders discussed other policy items that were of importance to HHC but were not included in the Governor's Executive Budget proposal. She informed the Committee that no proposed changes were made regarding Charity Care reimbursement/Disproportionate Share Hospital (DSH) funding. However, the MRT recommended that a new group should be convened to make specific recommendations related to this funding. Additionally, Ms. Saunders reported that the Governor had indicated in the supporting documents of his Executive Budget proposal that he planned to pursue a five-year Medicaid 1115 Waiver to provide support for the State's health care restructuring efforts. HHC is working closely with the State in the preparation of this Waiver.

Mrs. Bolus asked for further clarification regarding mandatory enrollment in long term care. Ms. Saunders responded that this provision was part of last year's enacted State budget, which required that all Medicaid recipients receiving more than 120 days of community-based long term care services enroll into a managed long term care program or other care coordination model or CCM. Mandatory enrollment of this population will be rolled out over a period of time beginning in April. There is an expectation that because of this rule, there will be a significant increase in fair hearing requests. Ms. Brown re-emphasized that this is specifically for community-based long term care and does not include institutionally-based long term care facilities (i.e. HHC's LTC facilities). She reminded the Committee that HHC's MetroPlus Health Plan had submitted an application to be approved as a managed long term care plan in preparation for this transition. Mr. Rosen asked if an indirect benefit would be the reduction in the cost of personal care. Ms. Brown responded that this effort is directed towards the utilization and the perceived overutilization of personal care. There is also recognition that people transitioning from personal care or who will experience changes in their current community-based long term care will have a lot of questions. It will be important for managed care plans or CCMs to acknowledge this and to put into place processes that will ensure that people have access to fair hearings.

Mr. Aviles asked if the requirement for language accessible prescription was directed to retail pharmacies. Ms. Brown responded affirmatively. Mr. Aviles further asked if the recommendation indicated the number of languages or the specific languages. Ms. Brown responded that the recommendation did not indicate the specific languages but focused on the languages that are predominant within a geographic area. Ms. Brown added that this was a longstanding effort on the part of the New York Immigrant Coalition, HHC and others and was a major success.

Ms. Brown informed the Committee that the Governor's Executive Budget proposal had changed HHC's approach in terms of its advocacy efforts for this budget cycle. She noted that the legislative events that are hosted by HHC's Community Advisory Boards at HHC facilities will occur this year. However, the planned advocacy trip to Albany that would usually include between 200 and 400 participants would not be conducted this year because the financial implications for HHC, based on the Executive Budget proposal, were not significant.

SUBSIDIARY BOARD REPORT

HHC Insurance Company / HHC Risk Services / HHC Physicians Purchasing Group – December 7, 2011 – As reported by Mr. Alan Aviles

The Corporation's initiative to reduce costs associated with medical malpractice claims includes efforts to identify cost-effective insurance strategies. The HHC Board of Directors authorized the formation and operation of two subsidiary captive insurance companies, the HHC Insurance Company and the HHC Risk Services Corporation, that would insure attending physician staff and provide access to excess insurance coverage provided by a State-funded pool. The HHC Physicians Purchasing Group was formed as an insurance purchasing group for HHC affiliated physicians.

Reports from the recent Board meetings held on December 7, 2011 are summarized below:

HHC Insurance Company

The HHC Insurance Company was licensed as a captive insurance company by the New York State Department of Insurance on December 16, 2004. It became active on January 1, 2005. The company underwrites primary professional liability coverage for attending physicians affiliated with HHC in the specialties of Obstetrics/Gynecology and Neurosurgery. Excess coverage for these specialties, obtained through the New York State Excess Liability Pool, began on July 1, 2005.

The Board of Directors of HHCIC held its annual meeting on December 7, 2011. It conducted all business necessary for captives in the State of New York including the issuance of primary insurance policies to the members of the HHC Physicians Purchasing Group as well as the re-appointments of Aon Risk Consultants, Inc. as actuaries and KPMG, LLP as auditors. At present, there are 323 Obstetrician/Gynecologists and Neurosurgeons insured through HHCIC. Of that number, 286 have excess coverage through MMIP. The remaining physicians are insured through other excess carriers.

Dr. Ross Wilson was elected Vice-President of the HHCIC, replacing Dr. Ramanathan Raju.

Premium in the amount of \$7.5 million was deposited for the benefit of HHCIC by HHC. It was loaned back to HHC by the Company and is held in reserve for the payment of any claims with the exception of any amounts needed for payment of any outstanding claims against HHCIC.

The Company was required to sign up as a plan or pool participant in the Medical Malpractice Insurance Pool (MMIP). The company opted to join the Pool so that it could be consistent with all of the other medical malpractice carriers in the State of New York. The September 30, 2011 cession statement from the Pool indicates that the Company has a net liability to the Pool of \$1,455,426.00.

The company was examined by the New York State Department of Financial Services (formerly the NYS Department of Insurance) in October 2010 with the report issued on April 6, 2011. The report was accepted by the HHCIC Board.

All Regulatory matters are current.

HHC Risk Services Corporation

The Board of Directors of the HHC Risk Services Corporation, a captive insurance company licensed in the State of Vermont, held its annual meeting on December 15, 2010. The meeting was held in New York with permission from the State of Vermont. The Board conducted all business necessary for captives in the State of Vermont including the re-appointments of Aon Risk Consultants, Inc. as actuaries and KPMG, LLP as auditors. All Regulatory matters are current.

The dissolution of the captive was approved by the HHC Board November 30, 2011. The Plan of Dissolution was approved by the Risk Board. The State of Vermont was notified of the intent to dissolve the insurance company and return the insurance license on December 2, 2011. The dissolution application with the plan of dissolution will be filed with the State of New York by December 30, 2011. Absent an unforeseen development, this is the final meeting of the Risk Services Board.

HHC Physicians Purchasing Group

The Board of Directors of the HHC Physicians Purchasing Group held its annual meeting on December 7, 2011. The business of the Group is to obtain primary medical malpractice insurance from HHCIC on behalf of its members who are employees of HHC's Affiliates. The physician members of the group have obtained primary medical malpractice insurance coverage in the amount of \$1.3 million/ \$3.9 million from the HHCIC, the New York captive insurance company. The members of the group have also received excess coverage in the amount of \$1 million / \$3 million from the Medical Malpractice Insurance Plan.

The Board conducted all business necessary for a Purchasing Group in the State of New York.

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

ALAN D. AVILES
HHC PRESIDENT AND CHIEF EXECUTIVE
REPORT TO THE BOARD OF DIRECTORS
February 29, 2012

HHC CELEBRATES PATIENT SAFETY AWARENESS MONTH

HHC will celebrate Patient Safety Awareness Week, March 4 to 10, with two major events on March 5th. First, at HHC's Patient Safety Champion Award ceremony, we will recognize an individual, team, unit or service from each facility who has served as a catalyst to transform the culture of safety in their organization. As in previous years, the outstanding work done by these Patient Safety Champions will be inspirational to everyone.

Then, as a further demonstration of HHC excellence in patient safety and teamwork, three teams that prevailed in a series of competitions on patient safety knowledge over the last several weeks will go head to head in the *Patient Safety FINAL Jeopardy: Battle of the Networks 2012*. The three winning network teams -- from the Generations Plus Northern Manhattan Network, the Queens Network and the North Bronx Network and Health & Home Care -- will compete to win HHC's Patient Safety Trophy for 2012.

Through these events HHC leaders from throughout our system, as well as Patient Safety Officers and Associates, and frontline staff will come together to celebrate our commitment to our patients and celebrate the progress we have made toward making HHC an even safer place to receive quality health care.

MEDICATION SHORTAGE

The issue of medication shortages has been in the press for well over a year. Unfortunately it is not getting better and in fact shows signs of getting worse. Chemotherapy, anti-microbials and anesthetic agents are the most common category of medication in short supply. The state and federal governments are aware and a recent FDA Bulletin was issued to increase awareness and to announce a new effort to increase chemotherapy availability by permitting importation from Europe. Every HHC facility is aware and the Pharmacy Directors and Medical Directors are coordinating those efforts. Medical staff are identifying alternative medications where feasible and restrictions are being placed on critical drugs in short supply to ensure optimum utilization.

**HHC HEALTH HOME CERTIFICATION FOR QUEENS AND MANHATTAN
EXPECTED IN MID-MARCH**

On February 15th, HHC submitted its application to the New York State Department of Health (DOH) for designation as a Health Home Provider in the boroughs of Queens and Manhattan and we expect to be certified by mid-March. Last month, DOH certified HHC as a Health Home Provider in the boroughs of the Bronx and Brooklyn.

As I mentioned to you in November, the Health Home initiative gives us a unique opportunity to further strengthen the quality and efficiency of care delivered to Medicaid patients with chronic

medical and/or serious behavioral health conditions. The Health Home initiative aims to improve health outcomes for these patients through focused care coordination, and to decrease costs by reducing the emergency visits and avoidable hospital admissions for this group of patients.

The fees to be paid via the Health Home program are to cover the cost of care coordination services and will average about \$100 per member per month. This payment comes in addition to any other reimbursement for the care delivery required by each patient.

We expect that the modest first wave of patients assigned to HHC through the Health Home program -- approximately 500 to 600 patients -- will largely receive services from existing care coordination programs at HHC hospitals. As we expand the numbers of Health Home patients, we will likewise expand the pool of care coordinators to provide these services.

FUNDING CUTS TO HHC INCLUDED IN ADOPTED LEGISLATION

On February 17th, the Senate and the House adopted the Middle Class Tax Relief and Jobs Creation Act of 2012, which President Obama signed into law on February 22. This law included a 10-month extension of the existing payroll tax reduction and extension of a temporary funding fix to sustain current Medicare reimbursement for physicians. Without it, physicians across the country would have experienced a 27.4 percent reduction in Medicare reimbursement.

To offset this spending, the law includes a one year extension, to federal fiscal year (FFY) 2021, of the Medicaid DSH cuts that are included in the Affordable Care Act that otherwise would have expired on September 30, 2020. This one-year extension would result in savings of \$4.1 billion for the federal government; however the impact on HHC – if our DSH funding is reduced proportionally - is an estimated \$421.8 million cut in funding in FFY 2021.

The law also includes a provision, effective on October 1, 2012, to reduce Medicare reimbursement for hospitals for “bad debts,” which typically include an inability to collect on patient co-pay amounts. This provision is estimated to save the federal government \$6.9 billion from FFY 2012 - 2022. The cost to HHC will be \$200,000 every year starting in FFY 2012, or an estimated total of \$1.9 million through FFY 2021.

On a bright note, with leadership from New York Senator Charles Schumer, proposed cuts in Medicare payments to hospital outpatient departments for Evaluation and Management Services were removed from the bill before passage. These proposed cuts would have resulted in a loss of \$186 million to HHC over ten years.

PRESIDENT OBAMA RELEASES PROPOSED FFY 2013 FEDERAL BUDGET

On February 13th, President Obama released the Administration's proposed federal budget for FFY 2013. Included were reductions to both the Medicaid and Medicare programs, totaling \$364 billion over ten years. The specific health care cuts mirror those that the President had submitted to the budget "Super Committee" in the fall of 2011. The Administration's proposals, if enacted, could result in reductions of \$1.5 billion to HHC over 10 years.

There are three Medicaid proposals of primary concern:

- A phase-down of states' use of Medicaid provider taxes from FFY 2015 to FFY 2017, to 3.5 percent starting in FFY 2015. New York State is currently at 5.5 percent. This proposal would save the federal government \$22 billion; however HHC would lose an estimated \$687.5 million over 10 years.
- A reconfiguration of states' FMAP (the federal Medicaid match) by replacing rates for Medicaid and Children's Health Insurance Program with a single lower rate that could save the federal government \$18 billion over 10 years. While there are still no legislative details, preliminary estimates are that HHC could lose \$277 million over 10 years.
- Extending the ACA-mandated Medicaid DSH cuts two years, to FFY 2022. This would save the federal government \$8 billion; however HHC would lose \$421 million each year. Note that the first year of this extension was included in the Middle Class Tax Relief and Jobs Act of 2012 adopted on February 17th by Congress.

On the Medicare side, there are several proposals of major concern to HHC:

- The proposal to reduce Indirect Medical Education payments by 10 percent starting in FFY 2014 would save \$10 billion nationally and cost HHC \$93.8 million over 10 years.
- The proposal to reduce reimbursements for Medicare bad debt from the current 70 percent to 25 percent over three years to save the federal government \$36 billion, would cost HHC an estimated \$15.3 million over 10 years.
- The Administration proposes several additional changes that would save the federal government an estimated \$63 billion and cost HHC \$36.7 million over 10 years, including:
 - Reducing payments to inpatient rehabilitation facilities (IRFs), long-term care hospitals, skilled nursing facilities (SNFs), and home health agencies by 1.1 percent beginning in FFY 2014 through FFY 2021;
 - Beginning in FFY 2013, equalizing payments to IRF with SNF payments for three conditions involving hips and knees, as well as other conditions selected by the Secretary of Health and Human Services; and
 - Reinstating in FFY 2013, the Medicare policy that required at least 75 percent of patients admitted to an IRF to have conditions that meet one or more of 13 designated severity conditions in order for that facility to qualify as an IRF.

**SCIENTIFIC AND TECHNICAL ADVISORY COMMITTEE RECOMMENDS
INCLUSION OF CANCER AS AN ELIGIBLE DIAGNOSIS FOR WTC HEALTH
FUNDING**

On February 16th, the Scientific and Technical Advisory Committee (STAC) of the World Trade Center Health Program recommended that some cancer patients be made eligible for health benefits through the World Trade Center Health Program. Last year, when Congress enacted the program to compensate and treat persons who were sick as a result of the events of 9/11, cancer was not enumerated as a diagnosis that was eligible for treatment and compensation from the program.

While the scientific debate is still in its early stages over whether higher rates of cancer are a direct and proven result of exposure to the 9/11 dust cloud and smoke, members of the STAC agreed that there is solid biological plausibility of a cancer link, given the numerous cancer causing toxins that were present at the site. They agreed, with near unanimity, that it was reasonable to expand the program now while the definitive research continues. While it is not yet clear exactly what the committee will conclude, it is anticipated a variety of cancers will be included in the STAC recommendation.

The Committee's recommendation, due by April 2, 2012, is advisory only. It can be accepted, rejected, or taken in part by the program's administrator, Dr. John Howard, Director of the National Institute for Occupational Safety and Health. If Dr. Howard decides to go forward to include cancers, his recommendation would be published in the Federal Register for comment.

We will keep you posted on further developments on this issue of importance to our own WTC Environmental Health Program and to all New Yorkers.

HHC REACHES OUT WITH 2012 COLON CANCER AWARENESS MESSAGE

In observance of National Colorectal Cancer Awareness Month in March, we will continue our message that Colon Cancer is Preventable, Treatable and Beatable. This week, the New England Journal of Medicine published the results of a 20-year study done in New York City which showed that the death rate from colorectal cancer was cut by 53 percent in those who had a colonoscopy and whose doctors removed pre-cancerous growths, known as adenomatous polyps.

Our awareness campaign will include a Colon Cancer webpage with compelling video messages from employees and patients with a direct appeal to colleagues, friends, family members and others, age 50 or over, to get a colonoscopy. We will also feature our staff and patients in brochures and posters printed in English and Spanish and placed prominently in our facilities.

Next week, Dr. Jason Gonsky, Director Hematology/Oncology at Kings County Hospital Center, and Dr. Margaret Kemeny, Director, Cancer Center at Queens Hospital Center will each have an article focused on the importance of colon cancer screening published in local newspapers, The Brooklyn Spectator and The Queens Courier. We also plan to use HHC's presence in the social media channels of Facebook, YouTube and Twitter to extend our colon cancer message during March.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

- Keeping the Heart Healthy, Dr. Brooks Mirrer, Woodhull Hospital, [News 12 Brooklyn - TV](#), 2/22/12
- Benefits of Breastfeeding, Dianne Velez RN, Lactation Consultant, Metropolitan Hospital, [NY1 Noticias -TV](#), 2/23/12
- Carnegie Hall Performers Bring Act To Queens Hospital, Queens Hospital, [NY1-TV](#), 1/24/12
- Brooklyn Officer Shot In Line Of Duty Heads Home, Dr. Ronald Simon, Bellevue Hospital, [NY1-TV](#), 2/10/12

Print and Online

- Nurses as Executives, Denise Soares, Harlem Hospital, Advance for Nurses, 1/30/12
- Helping Men Take Better Care of Their Health , Denise Soares, Harlem Hospital, New York Daily News, 2/21/12
- Twenty of the New York Region's Top Urban Health Specialist and Executives, Denise Soares, Harlem; Dr. Jean-Bernard Poulard, Queens Health Network; Tony Martin, HHC, NY Daily News, Urban Health Supplement, 2/21/12
- HHC Imports Expert In Health-Care Simulation For Bronx Institute, HHC, The Chief, 2/17/12
- In the name of public health, Jan/Feb issue, Antonio Martin, The Network Journal, February 2012
- MetroPlus Health Plan rated No. 1 for quality of care, patient satisfaction, HHC, Nurse.com, 2/20/12
(Also covered by Insurancenet.com)
- 10 Spine Surgeons Focusing on Trauma, Dr. Sheeraz A. Qureshi, Elmhurst Hospital, [Becker's Orthopedic & Spine Review](#), 2/22/12
- Harlem Hospital Puts ER Patients on the Fast Track, Dr. Maurice Wright, Denise Soares, Harlem Hospital, [DNAinfo.com](#), 2/9/12
- Reading before age 5? Experts say 'yes', Bellevue Hospital, [TheGrio.com](#), 2/21/12
- Offering Paid Sick Time Could Save the City Money, Report Says, HHC, [DNAinfo.com](#), 2/17/12
- Medical Care In Queens Ranks Among Best, Elmhurst Hospital, The Queens Gazette, 1/25/12
- Gouverneur Celebrates Chinese New Year, Gouverneur Hospital, The Lo-Down, 2/1/12
- Hospital Birth Costs: What to Expect, Dr. Aleksandr M. Fuks, Queens Hospital, Dr. Toni Stern, Coney Island Hospital, Learn Vest, 2/6/12
- Bellevue One of the Few, Dr. Jennifer Havens, Dr. Judith Joseph, Bellevue, Our Town, 2/8/12
- W.T.C. Health Registry to complete third survey, HHC WTC Environmental Health Center, [Downtown Express](#), 2/8/12
- Progress made on new building Foundation, HHC Sea View, [Staten Island Advance](#), 2/8/12

- DOH Rolls Out Asthma Grants, HHC, Crain's Health Pulse, 2/23/12
- Art Exchange Program, Fox 5 -TV, 1/25/12
- Lin-Manuel Miranda Partners with 'Lincoln Art Exchange' Program, Broadway World, 1/24/12
(Also covered in CBS New York, Bronx Times, Metro, Huffington Post, Buffalo Business First)
- Artists to barter talent for health care, The Amsterdam News, 1/26/12
- Lincoln Art Exchange barter health treatment, Lincoln, Bronx Times, 2/14/12
- En Hospital Lincoln los artistas pueden intercambiar seguro médico por su arte, Queens Latino, 1/26/12
(Also covered in Atanay.com)

**2011 Year in Review
President Alan D. Aviles
HHC Board of Directors
February 29, 2012**

Introduction

As has become my custom, I expand my remarks at the February Board meeting to reflect on the general state of HHC, to review some of the accomplishments and challenges of the past year, and to relate our current work to our strategic agenda moving forward.

This past year was again one of considerable challenge as we continued to tackle a daunting structural budget deficit and struggled to address it while maintaining our impressive patient safety and quality of care gains of recent years. On the brighter side, this past year also heralded the beginnings of a new era of healthcare reform in our state. The Governor's launch of an ambitious redesign of New York State's Medicaid program has the potential to change our healthcare system dramatically and for the better in the long term.

Even as we labored to make our system more cost-efficient last year, we also worked hard to further build a foundation upon which to construct a new healthcare delivery model that can thrive under a redesigned Medicaid program and ultimately under a reformed broader healthcare environment. Before I outline our work this past year to harness the potential promise of reform going forward, let me first summarize the fiscal challenges that you now know so well, our progress on closing our budget gap, and some highlights of our on-going work to improve access, quality of care, and our infrastructure.

The Fiscal Challenges Continue

Three years into the severe economic downturn across our State and our nation, another round of Medicaid reimbursement cuts stripped our system of more than \$170 million of annualized revenues, bringing the total cuts to HHC's annual Medicaid reimbursement base during the past three years to roughly \$500 million. Even as our Medicaid reimbursement falls dramatically, costs beyond our control continue to spiral; most notably our pension costs, which stood below \$50 million in 2004, but are projected to reach \$400 million next fiscal year. At the same time, the persistently high rate of unemployment drove more uninsured patients to seek care in our system. Of the 1.3 million patients we served, 478,000 – or 37% – were without insurance, a 6% increase in the number of our uninsured patients compared to 2010.

In Washington, recent cuts to the Medicare program, beyond those already made as part of the Affordable Care Act (ACA), have compounded our fiscal challenge. Still more Medicare and Medicaid cuts have been proposed in Congress (and by the President) and may yet be enacted later this year. And, of course, the looming deep cuts of the ACA to supplemental Medicaid and Medicare funding, upon which safety net providers disproportionately rely, will begin to take effect in 2014. HHC projects that it may lose more than one billion dollars in funding over the seven-year period between 2014 and 2020.

These reductions in reimbursements are but the leading edge of an unrelenting drumbeat going forward to reduce healthcare costs. Of course, the hurdles will be even greater for safety net systems such as ours because of our heavy reliance on Medicaid reimbursement that is now below the actual costs of providing care, and the fast-dwindling supplemental federal funding that supports our extensive service to the uninsured.

Against this threatening backdrop, we continued to execute our multi-year cost containment and restructuring plan to ultimately trim \$600 million from our projected budget deficit. To date, we have achieved roughly \$400 million of that goal. As the Board well knows, some of our cost-containment initiatives have been painful and have strained our relationship with our unions.

Our workforce now includes about 2500 fewer full-time employees than it did three years ago, with targeted attrition accounting for most of that reduction. To the credit of our dedicated employees, we have maintained virtually the same service capacity across all care settings despite having trimmed our workforce by more than 6%. In the main, most of our targeted attrition has not involved direct patient care positions.

Selective Outsourcing Has Staved Off More Cost-cutting Drastic Measures

In confronting our gaping budget deficit, we have explored – and devised plans to implement – every possible means to responsibly contain costs without closing or curtailing essential services and programs. This has led us to analyze whether certain of our services could be managed more efficiently through outside entities with deep expertise in these service areas. Where the analysis reflects that such efficiencies are attainable through this approach, we have elected to outsource these services (or the management of these services).

Indeed, much of the hospital industry across the country has increasingly contracted for select services to reduce unnecessary costs and our own recent experience confirms that such savings can be substantial. Our outsourcing of the management of our dietary services has saved HHC more than \$40 million in the past eight years and is projected to save even more in the coming

years now that the original capital investments in our centralized cook chill plant have been amortized.

This past year we completed the outsourcing of our laundry and housekeeping services, and we anticipate savings of \$242 million over the next nine years. Although these initiatives have displaced incumbent managers, we have worked to ensure that these employees are offered comparable managerial positions with the new external management entities. Similarly, not a single unionized worker has lost his or her job as a result of these outsourced services, as we have retrained and reassigned displaced workers to other comparable (and, at times, higher paying) positions.

Selective “Insourcing” Can Also Cut Costs

We also are committed to “insourcing” services currently performed by outside vendors where our analysis reflects that this will be more cost-efficient. As a result, during the past year we have recruited 54 new employees in our information technology operations to do the work formerly done by consultants. To date, this has saved HHC \$3.2 million on an annualized basis. We have targeted the insourcing of another 40 positions during the coming year.

Our multi-year cost-containment and restructuring plan includes more than 35 discrete initiatives that must be fully implemented by the end of FY 2014. The seven initiatives that were slated for completion in FY 2011 were executed and have yielded the projected savings, and we are presently on track to meet our FY 2012 fiscal objectives as well. Because some of the cost-containment initiatives slated for completion in FY 2013 and 2014 are complex and require significant lead time for execution, we have initiated the preliminary work on many of those already.

We are now tracking closely significant reductions in inpatient utilization that have appeared at most of our facilities over the last six months to assess whether, if sustained, they will require clinical staffing adjustments not now reflected in our financial plan.

Leveraging HHC’s Size through E-Commerce

Last year, HHC, in partnership with Global Healthcare Exchange (GHX), developed and implemented a new online purchasing system. The new system standardizes the ordering process and consolidates purchasing across HHC, helping us to achieve significant cost savings through higher discounts based on our purchasing volume. Under our new e-commerce system it now takes two hours to complete a purchase order from beginning to end, versus an average

of four days with the old paper system. GHX has put HHC on track to save approximately \$14 million in the first full year of use. Over time, HHC will migrate to a just-in-time delivery system, which will further reduce costs and inefficiencies associated with keeping excessive inventory on hand.

Breakthrough Teams Continue to Make Operations More Efficient and Effective

As HHC's process improvement tool, Breakthrough empowers frontline staff – the people who do the work – to determine ways to improve processes, remove wasteful steps and activities, and increase efficiency. When new processes and procedures are implemented, Breakthrough teams evaluate and monitor them, creating opportunities for continuous improvement.

Breakthrough continues to contribute significantly to operational efficiency and has reduced our costs while optimizing our revenue collection. As the Board knows, a central tool of Breakthrough is the RIE, a week-long rapid improvement event. During an RIE a front-line team experiments with and then implements changes that streamline and make more efficient the part of our operations within which they work. This past year, our facilities conducted 254 RIEs across 15 facilities, bringing the total number of RIEs over the last 4 years to more than 850. During this time, the improvements devised by Breakthrough teams have resulted in more than \$215 million in combined savings and new revenue. As of the end of 2011, more than 4,000 employees have participated in at least one RIE, and more than 11,000 employees have received some level of Breakthrough training.

Some Breakthrough teams have achieved truly impressive results. A handful of examples follow:

- **Jacobi Breakthrough teams dramatically improved the on-time start of surgical procedures, and significantly reduced patient waiting time. In less than a year, on-time starts of first of the day cases improved by 48%.**
- **At Bellevue, Breakthrough teams' efforts helped to decrease the average delay between surgical procedures by 68%, allowing an increase in the number of procedures completed, therefore generating significant additional revenue.**
- **At Queens Hospital, the time patients spent waiting in the Emergency Department between triage and seeing a provider dropped from 146 minutes to 47 minutes.**

Beyond the obvious benefits of empowering our own employees to make more efficient the work processes that they know so well, the spread of Breakthrough training and thinking throughout HHC is increasing our system's capacity for fairly rapid adaptive change. As the pace of change in our healthcare environments continues to quicken, this heightened adaptive capacity, fueled by the ingenuity and experience of our own employees, will prove invaluable.

Building on Patient Safety and Quality Gains While Addressing Unmet Community Needs

Even as we have focused on making our operations more efficient, we have worked hard this past year to sustain and build upon the significant gains of recent years in the quality of our care and access to our services. I will not catalogue all of the impressive clinical improvements over the last year, but I do want to provide a few illustrative examples.

We have made significant improvement at many of our sites in reducing urinary tract infection associated with urinary catheter use. In addition, further reductions in central line-associated blood stream infection at several of our sites have been achieved. Over the past two years, 2009 to 2011, seven HHC facilities have demonstrated a reduction in patient falls. Over the past year, five of our hospitals have reduced their rate of hospital-acquired pressure ulcers. Finally, the patient satisfaction scores of several HHC hospitals have improved significantly. HHC hospitals now have the highest patient satisfaction scores among all hospitals in each of the boroughs of Brooklyn, the Bronx, and Queens, and an HHC hospital has the third highest score in Manhattan.

Staff at HHC facilities continue to innovate around patient safety goals, and one good example is Metropolitan Hospital's Quiet Zones, which is aimed at eliminating medication errors by removing distractions to dispensing nurses. When nurses give medication to patients they don yellow belts, similar to crossing guard belts, alerting other staff and patients that they cannot be interrupted. This relatively inexpensive low-tech initiative is already showing significant impact at Metropolitan Hospital and is being replicated at other HHC facilities.

Our continued work around using our clinical information technology to drive improvements in care led Elmhurst Hospital Center to receive a 2011 IPRO Quality Award. Elmhurst received the award on the strength of the demonstrated collaboration between its medical-surgical nursing staff and the hospital's information technology team in using clinical IT to facilitate pain reassessment one hour post medication administration. The records of patients who need to be reassessed are easily viewed by nursing staff on the vital signs record in the EMR, and additional intervention occurs if pain has not been relieved.

Reducing maternal and infant harm in obstetrical care was a major focus of our improvement work across the system last year. For its compelling work in reducing adverse outcomes in labor and delivery, the North Bronx Healthcare Network's Women's Health Service recently received the prestigious National Association of Public Hospitals and Health Systems Safety Net Patient Safety Award, as well as HANY's coveted Pinnacle Award. The initiative implemented practices that effectively reduced certain adverse perinatal events, such as Erbs Palsy, and with the help of our Institute for Medical Simulation and Advanced Learning, are now being replicated across our system.

The Role of TeamSTEPPS and Just Culture Training

Last year we continued to deploy TeamSTEPPS communications training for clinical teams across our system. TeamSTEPPS was developed by the Department of Defense and the Association of Healthcare Research and Quality, and is a proven evidence-based method for enhancing patient safety by improving clinical team communication and performance. During 2011, we trained more than 4,000 clinical staff, bringing to nearly 11,000 the number of HHC staffers who have been through TeamSTEPPS training. Of these, about 700 have become master trainers and are qualified to teach TeamSTEPPS to their colleagues.

We also continued to train staff in Just Culture. This training supports our move toward a work environment that acknowledges the responsibility we all bear for improving our systems, communication, and teamwork to reduce the probability of error. It supports active reporting and analysis of significant medical errors while balancing individual accountability for avoiding reckless conduct with a non-punitive, systems-focused approach to reducing medical errors. In 2011, more than 900 managers received Just Culture training and nearly 6,000 staff members were trained in the basics of Just Culture.

IMSAL Becomes an Enterprise-Wide Training Resource for Safer Care

As you know, last year, HHC's newly constructed Institute for Medical Simulation and Advanced Learning (IMSAL) opened its doors and began providing state-of-the-art clinical training to individuals and clinical teams. Using high-fidelity patient mannequins, virtual reality simulators, and other advanced teaching modalities, IMSAL allows our clinical teams to practice and strengthen critical, often life-saving skills and to improve the communication and coordination dynamics that are the hallmark of high-performing teams. The nearly 3,000 employees trained by IMSAL last year are now better prepared to successfully tackle complex emergency situations with confidence.

Under the guidance of recently appointed Director Katie Walker, IMSAL is now working with HHC facilities to identify specific training needs and create additional courses to address them. IMSAL will develop rigorous metrics to evaluate the impact of its training, serving as an integral tool to continue our unyielding commitment to patient safety and quality care.

Continuing to Tailor Services to Meet Community Needs

Robust primary and preventive care, as well as early screening for incipient disease, has been an HHC priority for many years. During the past several years, HHC has pioneered making rapid HIV testing a routine service across many care settings – primary care, specialty care, the emergency department, inpatient units, and even our dental clinics. In 2011, we expanded testing yet again and improved care coordination to better manage chronic diseases that many HIV patients suffer, including hepatitis C.

This past year, HHC facilities tested 195,516 patients for HIV, more than three times the number tested just six years ago. For those patients that test positive, more than 90% are linked to appropriate medical treatment within our system. In December, we reached the milestone of performing our one millionth rapid HIV test. The CDC formally recognized us for this accomplishment and featured HHC's testing initiative on its website.

Recognizing that lesbian, gay, bisexual, and transgender (LGBT) individuals often lack access to truly patient-centered care, last May HHC launched a mandatory employee-training program. Our training program will help all staff to provide respectful, patient-centered and culturally competent healthcare services to the thousands of LGBT New Yorkers we serve each year. By focusing as well on the special clinical needs of the LGBT community, it will also help us to reduce health disparities that correlate with sexual orientation and gender identification.

Another area of special focus begun last year aligns with Mayor Bloomberg's Young Men's Initiative (YMI), a set of new policies and programs designed to reduce healthcare, social, and economic disparities that affect Black and Latino young men. One key HHC YMI effort is called "Guns Down, Life Up," a multi-faceted program designed in partnership with community-based organizations to confront and address behavior and risk factors that contribute to gun violence among adolescents and young men. This initiative, intended to decrease gun violence, and especially retaliatory gun violence among gang members, will be fully implemented at Harlem Hospital Center and Kings County Hospital Center this summer.

As an additional part of our YMI work, HHC has received funding to launch a teen and young adult health program that will seek to better engage young males in the healthcare system. We are creating a training program for our healthcare personnel to enhance their adolescent health knowledge and skills as well as bolster their ability to communicate effectively with young men about healthcare issues they face. We are experimenting with offering dedicated clinical hours for male adolescents at existing locations and initiating a peer-counseling program.

Completing our Facility Modernization Projects

Despite the deep cuts that HHC has had to make in its five-year capital plan, we are continuing to complete several important facility modernization projects. Our work at Harlem Hospital is on track for substantial completion by August 2012. This includes a new patient pavilion, the renovation of the existing Martin Luther King Jr. Pavilion, and preservation of the hospital's historic WPA Murals. Along Lenox Avenue, the spectacular multi-story glass facade that replicates one of the murals is already a Harlem landmark and a source of pride for one of HHC's most venerable and beloved institutions.

In November, Gouverneur Healthcare Services, in Manhattan's Lower East Side, completed the first phase of its major modernization, which includes a new Ambulatory Care Pavilion. The balance of the project, which includes a renovated, state-of-the-art skilled nursing facility with an additional 85 beds, will be completed by late 2013.

For many years, Lincoln Hospital Center has been New York City's busiest single site emergency department. In 2012, the final phase of Lincoln's renovation will make significant progress toward the ultimate completion of an expanded and modernized ED in May 2013.

In September, Morrisania Diagnostic and Treatment Center opened its new adult and pediatric suites, designed to help integrate a patient-centered medical home model of care. The expanded space co-locates "one-stop" services such as financial counseling, nutrition, and social work, and decreases patient waiting time.

We are also in the midst of an exciting project that involves our Goldwater and Coler campuses. By the end of 2013, we will have relocated Goldwater's long-term acute care hospital and skilled nursing facility operations to new facilities on the former North General Hospital Campus. "Goldwater North" will provide more space and greater privacy for patients and residents while also accommodating a new model of resident-centered programming. Goldwater North will have 164 skilled nursing facility beds and 201 acute long-term care beds.

Because Goldwater North will be substantially smaller than the existing facility on Roosevelt Island, we are working to identify community-based housing alternatives (with supportive services) for current Goldwater residents for whom such an alternative is appropriate. Approximately 300 Coler/Goldwater skilled nursing facility residents could be transitioned with home-and community-based services if affordable housing options can be identified. Therefore, we are actively working to secure discharge options for these individuals over the next 20 months, including the development of affordable housing for about 175 current Goldwater residents on a parcel on the Metropolitan Hospital campus.

Laying the Foundation to Succeed in a Reformed Healthcare Landscape

With a fundamental redesign of the Medicaid program legislated as part of last year's budget, virtually all Medicaid recipients, including those with the most complex needs, will be moved into a care management model of care within the next two to three years. With similar reforms set in motion at the federal level, focused on gradually introducing pay-for-performance into Medicare reimbursement, we began to pivot HHC into alignment with this healthcare reform trajectory toward more accountable care. Over the last year, this required of us a more purposeful and accelerated development of our system capabilities around robust primary and preventive care, proactive care management for patients with chronic disease, care coordination across settings, reduction of preventable admissions and readmissions, and effective use of clinical information technology to enable better care management.

Patient-Centered Medical Homes as the Hub of the Accountable Care Model

A patient-centered medical home (PCMH) is an advanced primary care practice model that employs a physician-led, team-based approach to ensuring comprehensive primary and preventive care, continuity, ready access, coordination of care and a systems-based approach to quality, safety and chronic disease management. PCMH is a foundational component of any healthcare delivery model that seeks to be both fiscally and clinically accountable for a patient's long-term health.

We have worked diligently to ensure that our primary care sites developed the full capabilities of a medical home. All 39 of HHC's primary care sites – both hospital and community-based -- that applied to the National Committee for Quality Assurance (NCQA) and New York State for PCMH certification have now been certified at level three, the highest level. This covers nearly 600 HHC primary care providers. Requirements to remain certified at level three become more stringent next year so our work continues as our facilities prepare to reapply in January 2013.

So far, our existing designations have qualified HHC for more than \$15 million in enhanced Medicaid reimbursement which we will re-invest in our primary care services.

HHC's Designation as a Health Home

The Affordable Care Act authorizes the federal government to fund 90% of the cost of care coordination for chronically ill patients through "Health Homes." Last year New York State established a "Health Home" program focused on Medicaid patients with two or more chronic illnesses or serious and persistent mental illness. The goal is to have designated "Health Home" networks use multidisciplinary teams of medical, mental health, and chemical dependency providers, together with social workers, nurses, and others, to ensure that enrollees receive needed medical, behavioral, and social services in accordance with a single care plan. There is an expectation that the Health Home program will reduce long-term healthcare costs by reducing the need for inpatient or other expensive institutional care. The program pays the Health Home for care management and coordination services on a per capita basis.

In December, HHC was designated a Health Home for eligible Medical patients in Bronx and Brooklyn. We have begun to establish linkages to community partners and to scale up our own care management infrastructure to accommodate the several thousand patients we expect to be assigned to us initially. And we have submitted our application for Health Home designation in Manhattan and Queens, and expect to receive such designation sometime in April.

Our evolving Health Home operation will be informed by our several years of experience with our state-funded Chronic Illness Demonstration Project (CIDP), which focused on developing care coordination approaches and resources that could successfully engage and help to better manage the care of patients with complex conditions and very high rates of healthcare utilization. Our CIDP patients, who typically struggle with chronic medical and behavioral health issues – and often with socio-economic stressors like homeless as well – mirror the most challenging of the Medicaid patients to be assigned to Health Homes. Late last year, we reported preliminary CIDP findings showing that our care coordination/management efforts reduced the average annual costs of the successfully engaged patients by roughly 20%, saving more than \$3.5 million for a cohort of 263 patients.

Once the state marries a shared savings reimbursement approach for underlying healthcare services provided to Health Home enrollees, we will have the beginning of payment reform that takes us toward an accountable care model.

Integrating Medical and Behavioral Health Care for the Mentally Ill

In November, Woodhull Hospital opened its new Center for Integrated Health. A model for facilitating a more holistic approach to addressing the medical and behavioral health needs of patients with mental illness, the new center will coordinate mental and physical health services for psychiatry patients in one setting. This is one of several initiatives under way across our system to assure that we are effectively meeting the general medical needs of our psychiatric patients who often suffer from chronic medical conditions beyond mental illness.

Our work in this area includes a major collaborative initiative, funded with \$9 million in funding from New York State, to improve the health status of New Yorkers diagnosed with schizophrenia. In a partnership known as InTouch, five HHC facilities (Elmhurst Hospital Center, Queens Hospital Center, Woodhull Medical and Mental Health Center, Cumberland Diagnostic and Treatment Center, Gouverneur Healthcare Services), the Urban Institute of Behavioral Health, the Creedmoor Psychiatric Center, and the New York City Department of Health and Mental Hygiene Bureau of Correctional Health Services have collectively formed an electronic information exchange coalition.

InTouch partners have put in an additional \$13 million in matching funds that, along with state support, will provide the technology, equipment, training, and technical assistance necessary to create interconnectivity through the Interboro Regional Health Information Organization (RHIO). The RHIO already supports electronic information exchange of clinical information among a number of New York City healthcare providers. The InTouch partnership will enroll 2,500 patients with a diagnosis of schizophrenia who have received primary care at one of the five HHC hospitals and are residents of a state-designated “care coordination zone” in Queens, North Brooklyn, and Lower Manhattan.

InTouch will allow participating healthcare providers to share medication lists, known allergies, laboratory and test results, as well as care and discharge plans for enrolled patients. The electronic link will also feature “care alerts” that can be sent to case managers and caregivers with real-time information to indicate whether the patients has visited an Emergency Department, been admitted to the hospital, and been discharged.

Electronic Medical Records and Meaningful Use

As you know, HHC was an early adopter of electronic medical record technology and we have won several national awards for our use of clinical information technology to drive improvements in care. Our EMR has allowed us to program alerts and “must enter” fields that help guide evidence-based care, and has facilitated coordination of care across the continuum

of care within our own system. We have embedded depression screening aids, asthma action plans, Coumadin dosing safeguards, and deep-vein thrombosis prophylaxis guides into our EMR, among other meaningful functionality. A data warehouse populated from the EMR has allowed us to run electronic chronic disease registries that have proven to be an effective tool in helping our clinicians better manage diabetes and hypertension. Indeed, partly as a result, all HHC facilities now qualify under NCQA's Diabetes Recognition Program as excellent providers of diabetes care.

Our current EMR has now been "certified" as compliant with the requirements for federal funding available under the America Recovery and Reinvestment Act (ARRA) for hospitals and physicians that demonstrate that they possess certified EMRs that also meet "meaningful use" requirements. We have begun the process of demonstrating "meaningful use" of our EMR in the various ways that will qualify us to begin receiving nearly \$200 million ARRA funds over the next several years. We expect to complete the process of documenting our compliance with "meaningful use" requirements for all of our facilities by July 2012.

Because our current EMR was first developed more than 20 years ago and lacks some of the capabilities that will be essential to manage patients across all care settings, to co-manage patients with partners outside our own system, and to involve patients more deeply in managing their own care, this past year we conducted an extensive review of state-of-the-art EMRs as part of a competitive procurement process. We will shortly select our new EMR vendor, seek the Board's contracting approval, and begin the complex process of migrating our more than 15,000 EMR users to a new, and much more powerful, system.

On a parallel track, we continue to develop the Interboro RHIO which, as mentioned above, is based upon technology that allows clinical data exchange among users of disparate EMRs. The Interboro RHIO now includes HHC and non-HHC facilities in Queens and Brooklyn and will be extended by the end of this year to facilities in Manhattan and Queens. At the present time, more than 350,000 patient records have been uploaded into Interboro's database. Going forward, our RHIO will ultimately be essential to enabling the informed co-management of patients with providers and facilities outside our own system.

All of this work to secure a robust clinical information technology platform across the entire enterprise is an essential foundation for our evolution to an organization that can collaborate internally and externally to coordinate care and manage the financial risk associated with emerging reimbursement models.

MetroPlus Becomes an Even More Important Partner and Strategic Asset

MetroPlus added membership again last year and ended 2011 with more than 420,000 enrollees. It remains the second-largest Medicaid managed care plan in New York City. Importantly, MetroPlus's Medicare enrollment increased by 27% last year and this will be a critical strategic area for future growth, especially as there is growing pressure to move patients dually eligible for Medicare and Medicaid out of fee-for-service and into a managed care model. For 2011, we estimate that having MetroPlus as our principal Medicaid managed care partner has allowed us to keep roughly \$80 million in premium revenue within our own health system, compared to what we would have experienced if we were forced to contract with other Medicaid managed care plans.

Even more impressive than MetroPlus's growth and contribution to HHC's bottom line is the plan's quality of care and patient satisfaction record. Last year the New York State Department of Health ranked MetroPlus first among all Medicaid managed care plans in New York State. This number one ranking, based on performance measures of quality and customer satisfaction, has secured MetroPlus a 2.5% premium increase, the maximum incentive award that can be achieved by any plan. This will add an estimated \$34 million to HHC's revenue in 2012, as MetroPlus will use this revenue to fund Quality Incentives and Pay for Performance pools.

MetroPlus also served as a co-applicant with HHC in our application to be designated as a Health Home, and the plan's experience with outreach to engage enrollees in care, as well as its care coordination experience, is helping to inform the care management infrastructure that we are building for Home Health enrollees.

And, in light of the State's announcement that it will soon begin channeling Medicaid patients who are eligible for long-term care into managed care plans, MetroPlus has applied to become, and expects to be approved as, a long-term care managed care plan. Mandatory managed care enrollment for long-term care eligible Medicaid recipients is expected to begin this summer.

Consolidation of our Affiliate Relationships to Better Align our Physician Workforce

The twin imperatives going forward of reducing the cost of care while improving health outcomes for patients and communities cannot be accomplished without a close collaboration with our physicians and other providers. With nine different affiliate entities employing our physician workforce, tight physician alignment with HHC's strategic goals and expeditious implementation of evidence- or consensus-driven best clinical practices has been exceedingly difficult. To address this dilemma, last year we completed the consolidation of four of our affiliates into one new affiliate, the Physician Affiliate Group of New York (PAGNY).

By later this year, we anticipate that our nine previous affiliate relationships will be reduced to three: Mt. Sinai, NYU, and PAGNY. We will seek to work very collaboratively with all three affiliates and their physician members to make the delivery of care within our system more efficient and effective, focusing on, for example, the reduction of preventable admissions and re-admissions, the reduction of lengths of stay for targeted DRGs, the reduction of nosocomial infections, better patient access, and increased patient satisfaction. To the extent that such close collaboration around patient-centered strategic goals results in additional revenue, or cost avoidance, we will look to structure our affiliation contracts so that such savings or gains can be shared with our physicians.

All of this work around PCMH and Health Home designation, the integration of medical and behavioral health care services, the enhancement of our clinical information technology capabilities, the strengthening partnership with MetroPlus, and the closer alignment and collaboration with our physicians are the underpinnings of our evolution toward an accountable care organization and position us to thrive under a reformed reimbursement system...a reimbursement system that will pay for improving the health status of patients, rather than the mere volume of services rendered.

Our Success, Past and Future, Derives from our Dedicated Workforce

The ability of HHC to meet the needs of our communities on a daily basis, to fulfill our mission as a safety net for the most vulnerable, and to transform into the future healthcare system that our patients need us to become is possible because of the extraordinary employees at every level of the organization who are deeply committed to our mission and our patients.

While it is not possible for me to begin to catalogue the individual contributions that make HHC the extraordinary organization that it is, let me conclude my yearly review with a handful of representative profiles of excellence.

- Not even Mother Nature can stop the indefatigable Joe Marcellino, who, along with his colleagues at Coney Island Hospital, orchestrated an unprecedented evacuation as Hurricane Irene approached New York City. Every patient was kept safe.
- Mitch Abidor, who began his career with HHC as a hospital care investigator 37 years ago, can't walk three steps through the halls of Queens Hospital without being recognized as an energetic Breakthrough leader. His passion for challenging the status quo and supporting reinvention that better serves patients empowers Breakthrough

participants as agents of change within their departments and inspires them to sustain improvements that transform the delivery of care.

- Eric Cliette, Director of the Injury Prevention Program at Harlem Hospital, and Dr. Robert Gore, founder of KAVI (the Kings Against Violence Initiative), show remarkable dedication to reducing violence among the youth of New York City and have launched their groundbreaking efforts as part of New York City's Young Men's Initiative. The Fund for HHC is supporting both of these programs.
- For Elva Rodriguez her work is not a job, but a calling. For 20 years, she has provided ob-gyn services to people in the community surrounding Segundo Ruiz Belvis D&TC, and served as a mentor and friend to countless patients and staff members. Her dedication and compassion was celebrated when she received the Fund for the City of New York's Sloan Award for Public Service in March of 2011.

And there are countless others....

As We Move Forward...

As our executive leadership team reviewed our strategic plan for the coming year, we realized that that even at a time of fiscal challenge there is one investment that still must be made... an investment in the personal and professional growth of our employees. This year, under the leadership of Senior Vice President Caroline Jacobs, we will begin to implement a comprehensive workforce development plan to better support our employees who want to acquire more skills relevant to a fast-changing healthcare environment and to help build leadership skills at every level of our organization.

I continue to be grateful for the opportunity to lead, together with our exceptional executive team in central office and at our networks, this extraordinary and vitally important organization at this critical time.

RESOLUTION

Ratifying the actions of the Capital Committee of the Corporation's Board of Directors (the "Capital Committee") in approving work orders involving expenditures by the New York City Economic Development Corporation ("EDC") in connection with its management and design of the Goldwater North Project (the "Project") totaling \$246,777,768 and authorizing the Capital Committee to approve on behalf of the Corporation's Board of Directors future work orders for EDC on the Project.

WHEREAS, on July 13, 2010 the Strategic Planning Committee of the Corporation's Board of Directors received a informational briefing regarding the plans for the development of Goldwater North; and

WHEREAS, the President signed the MOU with EDC as of November 1, 2010, an amendment dated July 7, 2011 and a further amendment dated October 26, 2011; and

WHEREAS, the Corporation's Board of Directors received a further informational briefing on October 31, 2011 by Senior Vice President LaRay Brown on the Project; and

WHEREAS, on May 26, 2011 the Corporation's Board of Directors approved a resolution authorizing the President to enter into a long-term lease for the former North General Hospital Building and to acquire the adjacent parking lot for the purpose of developing both properties into Goldwater North; and

WHEREAS, the Capital Committee has approved work orders for EDC in respect to the Project on November 10, 2010, February 10, 2011, December 6, 2011 and on February 9, 2012 in the total amount of \$246,777,768; and

WHEREAS, the Corporation's program of modernizing, renovating and constructing its health care facilities conducted since 1996 has been largely carried out with the Dormitory Authority of the State of New York ("DASNY") acting as the Corporation's construction manager and with the Capital Committee authorized to act on behalf of the Corporation's Board of Directors to authorize work orders issued to DASNY; and

WHEREAS, in the interest of good governance, it is appropriate for the Corporation's Board of Directors to explicitly ratify the Capital Committee's resolutions approving EDC work orders and to also explicitly authorize the Capital Committee to approve future EDC work orders for the Project, as was done with DASNY projects in the past, on the conditions set forth below.

NOW THEREFORE, be it

RESOLVED, that the actions of the Capital Committee of the Corporation's Board of Directors (the "Capital Committee") taken to approve work orders on November 10, 2010, February 10, 2011, December 6, 2011 and on February 9, 2012 in the total amount of \$246, 777,768 approving work orders

for EDC in respect to the Project in the form attached be and the same hereby are ratified and approved and adopted as the actions of the Corporation's Board of Directors. It is further

RESOLVED, that in the future, the Capital Committee shall be authorized on behalf of the Corporation's Board of Directors to approve work orders for EDC in respect of the Project provided, that the Capital Committee shall provide to the Board of Directors copies of all resolutions adopted in this regard and provided further that the Board of Directors reserves the possibility of modifying this resolution so as to require that any work orders for EDC be brought before the Board of Directors for approval from and after any such modification of this resolution.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a management contract with Johnson Controls, Inc. ("JC Inc") to manage the Corporation's plant maintenance operations for each HHC facility. The contract will be for a term of nine years in a total amount not to exceed \$363,191,470.

WHEREAS, given the projected financial position of the Corporation and the need to close a substantial deficit in the Corporation's budget the Corporation's Restructuring Leadership Committee identified Plant Maintenance operations management as a source of substantial savings; and

WHEREAS, a Request for Proposals ("RFP") was issued on September 9, 2010, seeking a plant maintenance company to enter into a contract with the Corporation to manage the full extent of the Corporation's plant maintenance operations; and

WHEREAS, a selection committee using criteria specified in the RFP determined that JC Inc, an entity whose core business is plant maintenance, had the highest rating of all of the proposers and will best meet the Corporation's requirements; and

WHEREAS, the JC Inc contract is estimated to save the Corporation \$127,992,493 which includes the corporation's labor force savings (see attachment A) over the contract's nine year term; and

WHEREAS, the Corporation's Restructuring Leadership Committee has reviewed and approved JC Inc's assumption of the Corporation's plant maintenance managerial function; and concluded that JC Inc's expert management will improve patient care, patient safety and assure substantial savings to the Corporation; and

WHEREAS, the Executive Vice President/COO shall be responsible for the overall management, monitoring and enforcement of the contract.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to negotiate and execute a management contract with Johnson Controls, Inc. ("JC Inc") to manage the Corporation's plant maintenance operations for each facility. The contract will be for a term of nine years in an amount not to exceed \$363,191,470.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a revocable license agreement with T-Mobile Northeast, LLC, (the "Licensee"), for use and occupancy of space for the operation of a cellular communications system at Coler-Goldwater Specialty Hospital & Nursing Facility, Coler Campus (the "Facility").

WHEREAS, in July 2007 the Board of Directors of the Corporation authorized the President to execute a license agreement with the Licensee which by its terms expires on October 31, 2012; and

WHEREAS, the Licensee desires to continue to operate a cellular communications system at the Facility, and the Facility has space suitable for the Licensee's needs; and

WHEREAS, the Licensee's use of the rooftop space will not compromise Facility operations; and

WHEREAS, the Licensee's cellular communications system complies with applicable federal statutes governing the emission of radio frequency signals and therefore poses no health risk.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to execute a revocable license agreement with T-Mobile Northeast, LLC, (the "Licensee"), for use and occupancy of space for the operation of a cellular communications system at Coler-Goldwater Specialty Hospital & Nursing Facility (the "Facility").

The Licensee shall be granted the use and occupancy of approximately 200 square feet of space on the roof of the "A-C" Building on the Facility's Coler campus (the "Licensed Space") for the operation of a cellular communications base station and related antenna equipment and accessories. The Licensee shall be responsible for paying for electrical and telephone services.

The Licensee shall pay an annual occupancy fee of \$52,840 per year, with an annual increase of 4% on the anniversary of the commencement date, for its use and occupancy of the Licensed Space.

The Licensee shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of its use of the Licensed Space, and shall provide appropriate insurance naming the Corporation and the City of New York as additional insureds.

The license agreement shall be revocable by either party on sixty (60) days prior notice. The term of this agreement shall not exceed five years without further authorization by the Board of Directors of the Corporation.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a revocable license agreement with T-Mobile Northeast, LLC (the "Licensee") for use and occupancy of space for the operation of a cellular communications system at Coler-Goldwater Specialty Hospital & Nursing Facility, Goldwater Campus (the "Facility").

WHEREAS, in January 2007, the Board of Directors of the Corporation authorized the President to execute a license agreement with the Licensee which by its terms expires January 31, 2012; and

WHEREAS, the Licensee's use of rooftop space for its equipment will not compromise Facility operations; and

WHEREAS, the Licensee's cellular communications system complies with applicable federal statutes governing the emission of radio frequency signals, and therefore poses no health risk.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to execute a revocable license agreement with T-Mobile Northeast, LLC (the "Licensee") for use and occupancy of space for the operation of a cellular communications system at Coler-Goldwater Specialty Hospital & Nursing Facility, Goldwater Campus (the "Facility").

The Licensee shall be granted the continued use and occupancy of approximately 200 square feet of space on the roof of the "E" Building on the Facility's Goldwater campus (the "Licensed Space") for the operation of a cellular communications base station and related antenna equipment and accessories. The Licensee shall be responsible for paying for electrical and telephone services.

The Licensee shall pay an annual occupancy fee of \$50,807 per year, or approximately \$254 per square foot. The occupancy fee shall be escalated by 4% per year.

The Licensee shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of its use of the Licensed Space, and shall provide appropriate insurance naming the Corporation and the City of New York as additional insureds.

The Goldwater facility will be vacated by late 2013. The license agreement may be terminated, prior to expiration of its five year term, with ninety (90) days prior notice to the licensee.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with Westat, Inc. (the "Licensee"), for a parcel of land for siting trailers in which the Licensee will conduct a U.S. Centers for Disease Control national health survey on the campus of Queens Hospital Center (the "Facility").

WHEREAS, in January 2007, the Board of Directors authorized the President to execute a license agreement with the Licensee which by its terms expired June 30, 2007; and

WHEREAS, the U.S. Centers for Disease Control (the "CDC") is engaged in an ongoing survey of national health conditions and desires to reestablish its program managed by the Licensee on the Facility's campus; and

WHEREAS, the Licensee, in cooperation with the New York City Department of Health and Mental Hygiene has conducted similar surveys in New York City including Queens County; and

WHEREAS, the Facility has land available suitable for siting the Licensee's trailers.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and is hereby authorized to execute a revocable license agreement with Westat, Inc. (the "Licensee"), for a parcel of land for siting trailers in which the Licensee will conduct a Centers for Disease Control national health survey on the campus of Queens Hospital Center (the "Facility").

The Licensee shall be granted the use and occupancy of a vacant parcel of land measuring approximately 8,000 square feet (the "Licensed Premises"). The Licensee shall pay an occupancy fee of \$3,000 per month. The term of the license agreement shall commence April 1, 2012 and end July 15, 2012.

The Licensee shall provide its own trailers and shall be responsible for all costs associated with the installation of the trailers and the operation of the survey program. The cost for all utilities shall be the responsibility of the Licensee. The Licensee shall also be responsible for providing its own security.

The Licensee shall take good care of the Licensed Premises, the curbs in front of, or adjacent to, the Licensed Premises, water sewer and gas connections, pipes and mains, and shall keep the Licensed Premises in good and safe order and condition, and shall make all repairs, interior and exterior, structural and nonstructural necessary to keep the Licensed Premises in good and safe order and condition.

At the end of the term of the License, the Licensee shall remove its trailers and restore the Licensed Premises to its condition prior to the term of the license.

**Page Two – Resolution
License Agreement – Westat, Inc.**

The Licensee shall keep clean and free from dirt, snow, ice, rubbish, obstructions and encumbrances the sidewalks, grounds, parking facilities, plazas, common areas, vaults, chutes, sidewalk hoists, railings, gutters, alleys, curbs or any other space in front of, or adjacent to, the Licensed Premises.

The Licensee shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out the use of the Licensed Premises and shall provide adequate insurance naming the Corporation and the City of New York as additional insured parties.

The term of the license agreement shall not exceed one hundred and five (105) days without further authorization by the Board of Directors and shall be revocable by either party on fifteen (15) days prior notice.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Tenant" or the "Corporation") to execute a lease agreement with Dr. Mikail Kantius (the "Landlord") for space at 79-18 164th Street, Borough of Queens, to house the Women, Infants and Children Program (the "WIC Program") operated by Queens Hospital Center (the "Facility").

WHEREAS, pregnant, breastfeeding and postpartum women, infants and children less than five years of age who are determined to be at nutritional risk are eligible for WIC Program services which include monitoring children's growth rates, nutrition education, breastfeeding support, and high risk counseling; and

WHEREAS, the WIC Program is currently located in a trailer on the Facility's campus and due to its lack of sufficient floor space, the program is unable to adequately service its existing caseload and will not be able to accommodate an anticipated caseload increase; and

WHEREAS, the additional floor area contained in the proposed 164th Street site will allow the program to better manage the current and future WIC caseload requirements.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Tenant" or the "Corporation") be and hereby is authorized to execute a lease agreement with Dr. Mikail Kantius (the "Landlord") for space at 79-18 164th Street, Borough of Queens, to house the Women, Infants and Children Program (the "WIC Program") operated by Queens Hospital Center (the "Facility").

The Tenant shall have use and occupancy of approximately 4,000 square feet of space on the ground floor of 79-18 164th Street (the "Demised Premises"). The initial term of the lease shall be three (3) years. The base rent shall be \$27.50 per square foot, or approximately \$110,000 per year. The base rent shall be escalated by 2.5% per year. In addition to the base rent, the Tenant shall pay its proportionate share of Common Area Charges ("CAM"), approximately \$2.50 per square foot and its proportionate share of real estate taxes, approximately \$4.50 per square foot. The lease term shall commence upon execution. The lease shall contain one (1) five-year option to renew exclusive to the Tenant.

The Landlord shall complete renovations to the Demised Premises in accordance with plans and specifications provided by the Tenant. The Landlord shall make renovations to the Demised Premises at an estimated cost of \$40,000. The Tenant shall reimburse the Landlord for the renovations when the work is substantially complete. Rent payments shall commence upon substantial completion of the Landlord's work.

The Landlord shall make all interior and exterior structural repairs to the Demised Premises, including repairs to the roof, infrastructure, window frames, plumbing, electrical, waste utility lines, common areas, curbs and sidewalks. The Tenant shall be responsible for non-structural repairs and maintenance.

Utilities including electricity, gas, and water shall be separately metered and payment shall be the responsibility of the Tenant.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with the Richmond County Medical Society and the Academy of Medicine (the "Licensee") for use and occupancy of space to house administrative functions at the Sea View Hospital Rehabilitation Center and Home (the "Facility").

WHEREAS, in January 2007, the Board of Directors authorized the President of the Corporation to enter into a license agreement with the Richmond County Medical Society and the Academy of Medicine, which by its terms expires on February 29, 2012; and

WHEREAS, members of the Richmond County Medical Society and the Academy of Medicine, founded in 1808, include physicians who practice medicine in the Borough of Staten Island; and

WHEREAS, the Licensee's purpose is to extend medical knowledge and advance medical science; elevate the standards of medical education; secure the enactment of just medical and health laws; encourage dialogue among society members and fellow physicians; safeguard the professional and economic integrity of society members, maintain appropriate and equitable relationships with the public and healthcare organizations; and increase public awareness of all aspects of the field medicine; and

WHEREAS, the Facility has available space in the Administration Building to accommodate the Licensee's needs.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with the Richmond County Medical Society and the Academy of Medicine (the "Licensee") for use and occupancy of space to house administrative functions at the Sea View Hospital Rehabilitation Center and Home (the "Facility").

The Licensee shall be granted the use and occupancy of approximately 350 square feet of space in the Administration Building (the "Licensed Space"), Monday through Friday, from 9:00 a.m. to 5:00 p.m. The Licensee shall pay an annual occupancy fee of \$7,308. The Licensee shall be responsible for the cost of maintenance, and housekeeping.

The Licensee shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of the use of the Licensed Space and shall provide appropriate insurance naming the Corporation and the City of New York as additional insured parties.

The license agreement shall not exceed five (5) years without further authorization by the Board of Directors of the Corporation and shall be revocable by either party on sixty (60) days prior notice.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Landlord") to execute a revocable license agreement with Con Edison Company of New York, Inc. (the "Licensor"), for use and occupancy of space for the operation of a radio communication system at Harlem Hospital Center (the "Facility") for five years without further authorization by the Board of Directors of the Corporation.

WHEREAS, in March 2007, the Board of Directors of the Corporation authorized the President to execute a license agreement with the Licensee which by its terms expires April 30, 2012; and

WHEREAS, the Licensee, a public utility, desires to continue operating a radio communication system on the roof of the Martin Luther King Pavilion; and

WHEREAS, the Licensee's continued use of the rooftop space for this installation shall have no impact on patient or staff safety and shall not compromise Facility operations; and

WHEREAS, the Licensee's radio communications system complies with applicable federal statutes governing the emission of radio frequency signals.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with Consolidated Edison Company of New York, Inc. (the "Licensee"), for use and occupancy of space for the operation of a radio communication system at Harlem Hospital Center (the "Facility").

The Licensee shall be granted the continued use and occupancy of approximately fifty (50) square feet of space on the roof of the Martin Luther King Pavilion (the "Licensed Space") for the operation of a Radio Frequency (RF) communications system. The Licensee shall pay an occupancy fee of \$27,007 per annum with an annual increase of 3% on the anniversary of the commencement date for its use and occupancy of the Licensed Space. The Licensee shall be responsible for paying for electrical service.

The Licensee shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of its use of the licensed space, and shall provide appropriate insurance naming the Corporation and the City of New York as additional insureds.

The License agreement shall be revocable by either party on ninety (90) days prior notice. The term of this agreement shall not exceed five (5) years without further authorization by the Board of Directors of the Corporation.

EXECUTIVE SUMMARY
LICENSE AGREEMENT
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
HARLEM HOSPITAL CENTER

The President seeks the authorization of the Board of Directors of the Corporation to execute a revocable license agreement with Consolidated Edison Company of New York, Inc. ("Con Ed"), for its continued use and occupancy of space to operate a radio communication system at Harlem Hospital Center ("Harlem").

The radio system installed at Harlem enhances Con Ed's ability to service the local community during emergencies and scheduled service operations. The system increases data monitoring, enabling local power usage demands to be effectively transmitted to Con Ed central operations, and its improved voice channel capability allows service crews access to required resources facilitating timely service restoration.

The Con Ed radio system operates at both the 800 megahertz ("MHz") and 900 megahertz ("MHz") frequency. The 800 megahertz iDEN System is a Motorola Radio Frequency ("RF") communications system for voice communications. The 900 MHz Data System is used by Con Ed's electric system operators to monitor and control electric distribution equipment remotely.

Con Ed will be granted the continued use and occupancy of approximately fifty (50) square feet of space on the roof of the Martin Luther King Pavilion. Con Ed will pay an occupancy fee of approximately \$27,007 per annum, with an annual increase of 3% on the anniversary of the commencement date for its use and occupancy of the licensed space. Con Ed will be responsible for paying for electrical service. Con Ed is responsible for all system maintenance.

Con Ed shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of its use of the licensed space, and shall provide appropriate insurance naming the Corporation and the City of New York as additional insureds.

The license agreement shall be revocable by either party on ninety (90) days prior notice. The term of this agreement shall not exceed five (5) years without further authorization by the Board of Directors of the Corporation.

ANTENNA AGREEMENTS

Facility	Licensee	Occupancy Fee (\$)	Price/Square Foot (\$)	Board Approval
Harlem	Con Edison	27,007	540	TBD
Coler	T-Mobile	52,840	264	TBD
Goldwater	T-Mobile	50,087	254	TBD
Goldwater	Sprint-Nextel	54,170	339	TBD
Lincoln	Sprint-Spectrum	80,812	269	9/2011
Coler	Sprint-Nextel	31,200	125	6/2011
Sea View	U.S. Government	7,939	52	7/2010
NCB	NYPD	waived	n/a	10/2009
Coler-Goldwater	Metro PCS	90,360	226	6/2009
Harlem	Con Edison	23,996	480	3/2007
Coney Island	U.S. Government	6,919	46	7/2007

Explanation of Charges:

Government entities typically pay lower occupancy fees for the space their antenna equipment occupies. The fees paid by private firms are heavily influenced by the degree to which the equipment will enhance system coverage in the area. Carriers are willing to pay a higher rate for those antenna sites where the installation significantly improves signal coverage.

RESOLUTION

*Authorizing the Executive Director of **MetroPlus Health Plan, Inc.** (“MetroPlus”) to negotiate and execute a contract with **Healthplex, Inc.** (“Healthplex”) to provide administration of dental services for a term of three (3) years with two (2) options to renew for one (1) year each, solely exercisable by MetroPlus, for an amount not to exceed \$4.9 million per year.*

WHEREAS, MetroPlus, a wholly-owned subsidiary corporation of the New York City Health and Hospitals Corporation (“HHC”), is a Managed Care Organization and Prepaid Health Services Plan, certified under Article 44 of the Public Health Law of the State of New York and;

WHEREAS, the Certificate of Incorporation of MetroPlus reserves to HHC the sole power with respect to MetroPlus entering into contract, other than with HHC or a health care service provider, with an annual value in excess of \$1,000,000; and

WHEREAS, MetroPlus provides dental benefits for approximately 60,000 members in its Child Health Plus, Family Health Plus and Medicare Advantage plans, and effective July 1, 2012 MetroPlus will also begin providing dental benefits for approximately 350,000 members enrolled in its Medicaid Managed Care and HIV-SNP plans; and

WHEREAS, MetroPlus seeks to provide a fully integrated dental program to its members working with its selected vendor towards the goal of improving health and reducing health care costs; and

WHEREAS, a Negotiated Acquisition for administration of dental services was issued in compliance with MetroPlus’ contracting policies and procedures;

WHEREAS, Healthplex was the vendor selected to provide these services; and

WHEREAS, the Board of Directors of MetroPlus has duly considered and approved the proposed contract between MetroPlus and Healthplex.

NOW THEREFORE, be it

RESOLVED, that the Executive Director of MetroPlus is hereby authorized to negotiate and execute a contract with Healthplex to provide administration of dental services for a term of three (3) years with two (2) options to renew for one (1) year each, solely exercisable by MetroPlus, for an amount not to exceed \$4.9 million per year.

FOR HHC BOARD OF DIRECTORS

***Authorization for MetroPlus Health Plan, Inc. to Enter into
An Agreement with
Healthplex, Inc.***

MetroPlus Health Plan, Inc. (“MetroPlus” or the “Plan”) seeks to negotiate and execute a contract with Healthplex to provide administration of dental services for a term of three (3) years with two (2) options to renew for one (1) year each, solely exercisable by MetroPlus, for an amount not to exceed \$4.9 Million per year.

Because contracts over the amount of one million dollars per year are reserved in the certificate of incorporation of MetroPlus to the New York City Health and Hospitals Corporation (“HHC”), the negotiated acquisition process was undertaken and HHC Board authorization is now sought to enter into an agreement with the selected vendor. The MetroPlus Board of Directors has approved submission of these agreements to the HHC Board for authorization.

In December 2011, managed care plans were notified that dental benefits for the Medicaid population would be carved back into the plans as of July 1, 2012. This created a time constraint because the Plan needed to have a vendor in place and implementation services to begin by April 1, 2012. The Plan released a Negotiated Acquisition (“NA”) in December 2011 and the purpose of the NA was to select a vendor to provide administration of dental services for MetroPlus, with demonstrated expertise and extensive experience required in providing all aspects of the dental benefit to members enrolled in Medicaid Managed Care, HIV-SNP, Family Health Plus, Child Health Plus, and Medicare Advantage Part D plans. Healthplex was selected to provide these services directly to MetroPlus.

MetroPlus is committed to making sure its members have access to the highest quality care and service, while maintaining affordability. MetroPlus is seeking a vendor to provide administration of dental services, including credentialing and maintenance of a dental provider network, dental claims processing, utilization management, provider and member call center support, and network management that will meet MetroPlus’ needs for the next three years. MetroPlus does not have the resources or systems to conduct these functions. MetroPlus currently provides dental services through an existing vendor relationship to members in the Family Health Plus, Child Health Plus and Medicare populations (approximately 60,000 members), and will begin providing services to our Medicaid membership (an additional 350,000 members) effective July 1, 2012.

Background of Healthplex

Healthplex is a New York based dental management company that has been providing dental benefit management services since 1977. Their clients include health plans, commercial employer groups, municipalities, and unions. Currently they administer programs for over 2.3 million members. Healthplex serves both Medicaid and Medicare members and has done so for 20 years.

The vendor contract is for a term of three (3) years with two (2) one (1) year options to renew for one (1) year each, solely exercisable by MetroPlus. Implementation discussions will begin in April 2012, with a go live date of July 1, 2012.

CONTRACT FACT SHEET

MetroPlus Health Plan, Inc.

A subsidiary corporation of New York City Health and Hospitals Corporation

For RFP, RFB, PSA, SS, NA

Contract Title: Administration of Dental Services
Project Title & Number: # 100912N010
Project Location: MetroPlus Health Plan
Requesting Dept.: Provider Contracting

Successful Respondent:	Healthplex
Contract Amount:	Not to exceed: \$ 4.9M annually
Contract Term:	Three years with two options to renew for one year each.

Number of Respondents: 2

Range of Proposals: Varied

Minority Business Enterprise Invited: Yes

Funding Source
 Capital
 General Care
 Grant: Explain
 Other: [General Operating Fund]

Method of Payment
 Lump Sum
 Per Diem
 Time and Rate
 Other: [As invoiced]
(required for contracts that exceed the amount of \$25,000)

EEO Analysis: Yes No

Compliance with HHC's McBride Principles Yes No

Vendex Clearance
 Yes No - in process, at MOCS since April 2011
(if applicable)

Privacy Addendum: Yes No - done with contract

CONTRACT FACT SHEET (continued)

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

Various levels of dental coverage are included in the benefit packages that MetroPlus is required to provide to its members, depending on line of business. MetroPlus is seeking a vendor to provide administration of dental services, including credentialing and maintenance of a dental provider network, dental claims processing, utilization management, provider and member call center support, and network management that will meet MetroPlus' needs for the next three years. MetroPlus is also looking for the vendor to provide implementation services beginning April 1, 2012 to ensure that the program is implemented by July 1, 2012. MetroPlus currently provides dental services through an existing vendor relationship to members in the Family Health Plus, Child Health Plus and Medicare populations (approximately 60,000 members), and expects to begin providing services to our Medicaid membership (an additional 350,000 members) effective July 1, 2012, per New York State Department of Health requirements. MetroPlus would look for all plan membership to be serviced by a single vendor.

Contract Application Approval (not applicable to PSA or RFB)

Was the proposed contract application approved? (include date): **January 24, 2012**

Has the proposed contract's scope of work, timetable, budget, contract deliverables or accountable person changed since the approval of the Contract Application? If so, please indicate how the proposed contract differs since that approval:

No

CONTRACT FACT SHEET(continued)

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

Selection Committee Members (Applicable to RFP, RFB, or NA)

(For RFP, RFB or NA only: Need to have an odd number of persons but no less than 5 upper/mid-level managers and that includes 3 persons from different departments)

(For PSA or SS: Project Manager and Department Head)

Susan Sun, MIS

Barry Ritter, Finance

Dianna Coles, Quality Management

Maria Rivera, Customer Services

Erin Carney, Provider Contracting

Firms Responding (Applicable to RFP, RFB, PSA or NA)

Healthplex

DentaQuest

Firms Considered (Applicable to RFP, RFB, PSA or NA)

Healthplex

DentaQuest

Justification of Vendor Selection (Provide greater detail for Sole Source, Negotiated Acquisition or PSA)

Healthplex was selected as the vendor showing the greatest demonstrated experience in providing all aspects of the dental benefit program as outlined in the NA and will minimize the administrative and medical/dental costs related to the provision of dental benefits, while maintaining a high level of member satisfaction and access. The financial structure of the Healthplex proposal, network disruption, a strong outreach presence, and quality measures were the key factors in the selection committee's decision.

CONTRACT FACT SHEET (continued)

Why can't the work be performed by Corporation staff?

The Plan lacks the internal resources and systems to provide dental benefits to its 410,000 members.

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

No artistic/creative/intellectual property will be produced.

Contract monitoring (include which Executive Staff is responsible):

The contract will be monitored by Joseph Dicks, Director, Provider Contracting.

CONTRACT FACT SHEET (continued)

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

(applicable to contracts that exceed \$25,000)

Received By E.E.O.

February 17, 2012

Analysis Completed By E.E.O.:

Approved on February 24, 2012

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: Kathleen Nolan, Contract Administrator
for Corporate Affairs
MetroPlus Health Plan

FROM: Manasses C. Williams 

DATE: February 24, 2012

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

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

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): MetroPlus Health Plan

Contract Number: _____

Project: Administration of Dental Services

Submitted by: MetroPlus Health Plan

EEO STATUS:

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

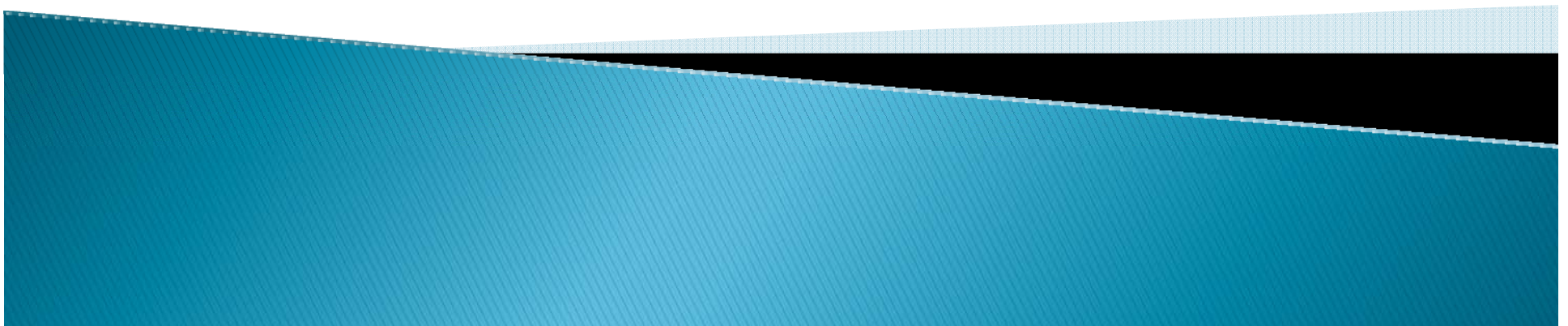
COMMENTS:

MCW/srf

MetroPlus Negotiated Acquisition for Dental Services

Presentation to the
HHC Board of Directors

March 22, 2012



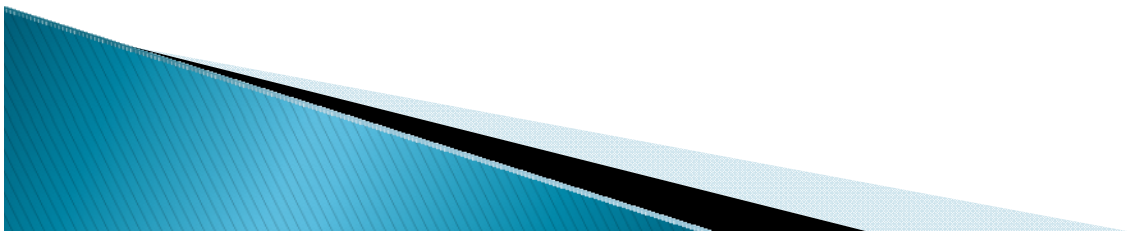
Current State – MetroPlus Dental

- ▶ MetroPlus contracts with DentaQuest to provide dental and administrative services for MetroPlus members enrolled in Child Health Plus (CHP), Family Health Plus (FHP), and Medicare Advantage programs
- ▶ In 2011, the Administrative Cost of the Dental Program was \$516,000. The Dental/Medical spend was \$9.3 million.
- ▶ MetroPlus has determined that it is not efficient to provide these services in-house, and almost all other New York based PHSPs outsource dental services
- ▶ MetroPlus is one of the few plans in New York State that does not currently manage the dental benefits for our Medicaid membership
- ▶ NYSDOH advised that all plans will be required to administer dental services for their Medicaid population beginning July 1, 2012



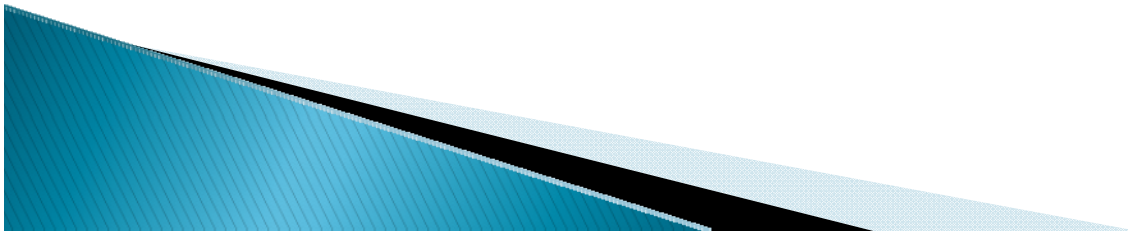
Medicaid Dental Concerns

- ▶ The major areas of concern related to the “Carve In” of the Medicaid Dental program are:
 - Financial impact to the Plan – both administrative costs and medical/dental costs
 - Quality impact on MetroPlus’ QARR scoring, SDOH incentives, etc. Dental Access rates factor into Plan’s QARR scoring
 - The challenge of transitioning 360,000 Medicaid members to a managed benefit – implementation, cost, avoiding disruption



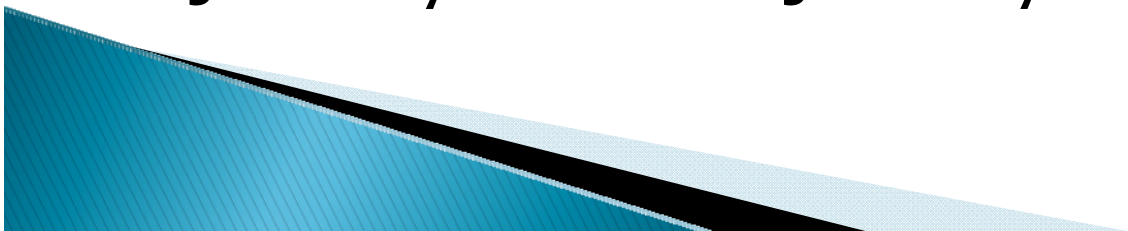
Dental Strategy

- ▶ From an efficiency perspective, all lines of business (except MetroPlus Gold) should be under the same Dental Vendor
- ▶ Two contracts are required:
 - An IPA Agreement covering the network of dentists who will service our members
 - A Management Services Agreement (MSA) covering the administrative functions to be provided: Claims Review and Payment, Customer Services, Utilization Management, Reporting, etc.



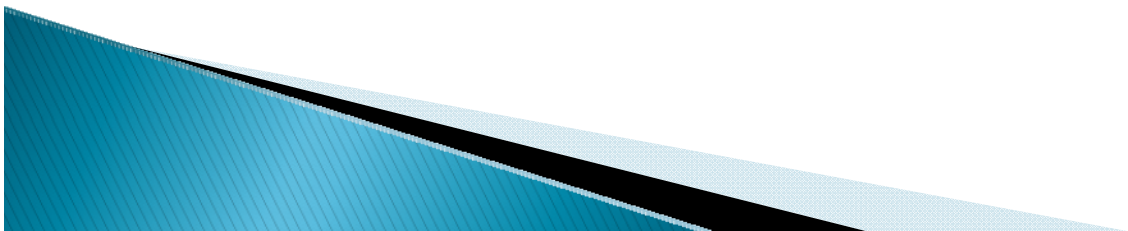
Negotiated Acquisition Process

- ▶ Pre-Qualification requirements issued (experience with Medicaid, New York State, minimum current enrollment, etc.)
- ▶ Two responders qualified – DentaQuest (the incumbent) and Healthplex
- ▶ These two organizations were provided with the Negotiated Acquisition documents
- ▶ Responses were received on January 17th
- ▶ In-person presentations took place on January 24th and January 27th



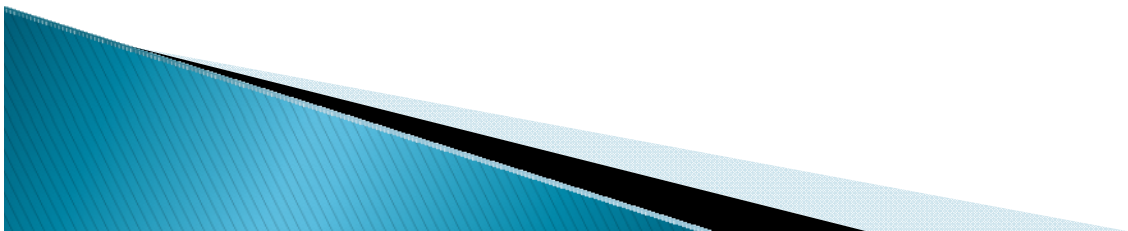
Negotiated Acquisition Process (cont'd)

- ▶ The MetroPlus Selection Committee represented the Contracting, Finance, Quality Management, Customer Services, and MIS departments
- ▶ Committee members evaluated quality of service, experience, disruption analysis, and financial costs, among other criteria
- ▶ Both vendors were given the opportunity to improve their proposal prior to final selection



Selection Committee Recommendation

- ▶ After deliberation and scoring of key criteria, the Selection Committee recommended contracting with Healthplex
- ▶ Financial structure of the agreement, low network disruption, a strong outreach presence, and quality program were the key factors in this decision
- ▶ Administrative costs are slightly higher with Healthplex, but these are balanced by a lower projected dental/medical spend and a more comprehensive Quality Program



Financial Proposals

	DentaQuest	HealthPlex
Projected Annual Administrative Costs:	\$3.5 million	\$3.9 – \$4.9 million*
Projected Annual Dental Spend:	\$56 million	\$50 million
Projected Total Annual Cost:	\$59.5 million	\$53.9 – 54.9 million
Projected Administrative PMPM:	\$0.71	\$0.77 – \$0.97*
Projected Dental PMPM:	\$11.11	\$9.92

*some costs are incentive based and may vary; costs may also shift from Administrative to Dental, based upon measures

These costs represent projections for CHP, FHP, and Medicaid lines of business

Remaining Process

- ▶ HHC Board approval for the Management Services Agreement
- ▶ Finalize incentives tied to quality measures and performance guarantees
- ▶ Contract language is finalized (provided during the N.A. process)
- ▶ Execute Agreements (Management Agreement and IPA Agreement) and begin implementation on or about April 1 for a July 1, 2012 go-live
- ▶ Coordinated implementation plan with all impacted MetroPlus departments

