AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: March 12th, 2015
Time: 9:00 AM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES
February 12th, 2015

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

CHIEF INFORMATION OFFICER REPORT — **MR. GUIDO**

INFORMATION ITEMS:

1. **Epic Implementation Clinical Sign-off Overview** — **MS. O'DONNELL**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: February 12, 2015

ATTENDEES

COMMITTEE MEMBERS

Vincent Calamia, MD, Committee Chair
Josephine Bolus, RN
Ram Raju, MD President
Hillary Kunins, MD, (representing Dr. Gary Belkin in a voting capacity)

HHC CENTRAL OFFICE STAFF:

Machelle Allen, MD, Deputy Chief Medical Officer, Office of Health Care Improvement
Maricar Barrameda, Assistant Vice President of EITS
Janette Baxter, Senior Director, Risk Management
Nicholas V. Cagliuso, Assistant Vice President, Office of Emergency Management
Deborah Cates, Chief of Staff, Board Affairs
Michael Coppa, Legal Intern, Legal Affairs
Juliet Gaengan, Senior Director, Quality & Innovation
Kenra Ford, Assistant Vice President Clinical Lab Operations/M&PA
Caroline Jacobs, Senior Vice President, Safety and Human Development
Christina Jenkins, MD Senior Assistant Vice President, Quality & Performance Innovation
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Susan Kansagra, Assistant Vice President, Population Health
Patricia Lockhart, Secretary to the Corporation
Katarina Madej, Director Communication and Marketing
Glenn Manjorin, Director, Enterprise It Service
Ana Marengo, Senior Vice President, Communications & Marketing
Randall Marks, Chief of Staff, President Office
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
Ian Michaels, Media Director, Communication and Marketing
Deirdre Newton, Senior Counsel, Legal Aaffairs
Bert Robles, Senior Vice President, Chief Information Officer
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Lynnette Sainbert, Assistant Director, Board Affairs
Marisa Salamone-Geason, Assistant Vice President, EITS
Diane E. Toppin, Senior Director, M&PA Divisional Administrator
Ross Wilson, Senior Vice President/Corporate Chief Medical Officer, Medical and Professional Affairs

FACILITY STAFF:

Gregory Almond, MD Chief Medical Officer (Acting), Metropolitan Hospital
Ernest J. Baptiste, Executive Director, Kings County Hospital Center
John Maese, MD, Medical Director, Coney Island Hospital
Anthony Rajkumar, Acting Executive Director, Metropolitan Hospital Center

OTHERS PRESENT

Todd Cape, CFO, GSI Health
Moira Dolan, Senior Assistant Director, DC37
David N. Hoffman, Chief Compliance Officer, PAGNY
Richard McIntyre, Siemens
Kristyn Raffaele, Analyst, OMB
Arnold Saperstein, MD Executive Director, MetroPlus
Dhruneanne Woodrooffe, Analyst OMB

MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, February 12, 2015

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 9:00 AM. The minutes of the January 15, 2015 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT

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

Care Management

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

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

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

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

Accountable Care Organization (HHC ACO)

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

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

Laboratory Services

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

GENERAL

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

Work Standardization

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

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

NSLIJ Reference Testing

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

Pandemic Flu Tabletop Exercise

On February 11, a system wide tabletop exercise was conducted simulating an H5N1 (Avian) flu pandemic in NYC. The corporate Emergency Operations Center as well as each facility command centers were activated and linked by video. Three scenarios were tested against the current facility plans, with many learning opportunities. Dr Joseph Masci served as subject matter expert for the event. Each facility is having a debrief with a view to providing any needed revisions to their facility pandemic plans; these plans will again be reviewed after this by the HHC Emergency Preparedness Council.

METROPLUS HEALTH PLAN, INC.

Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of January 1, 2015 was 465,058. Breakdown of plan enrollment by line of business is as follows:

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

As we still find ourselves in the Open Enrollment Period, complete information on QHP membership is not yet available. Although the December 2014 QHP membership was 35,424 and the January enrollment figure above is 25,082 QHP members, we are concerned that we will experience further membership loss in this line of business. We estimate to have approximately 18,000 paid, effectuated members as of the date of this report. The difference (which cannot be

counted as confirmed membership) consists of both active members in their grace period (who still have the option to transfer out) and members who have not yet renewed. One of the reasons for the membership drop is that there was a significant number of previously APTC members (approximately 6,000) who had not validated their status on the NYSOH website for the new enrollment period. NYSOH automatically re-enrolled them as non-APTC members which lead to MetroPlus having to bill these members full premium for the month of January. Some of these members did validate their status in the meantime, and therefore should receive APTC credit starting in February. However, absent their full understanding of what caused the full premium invoices, we cannot guarantee they will remain with MetroPlus.

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

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

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

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

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

CHIEF INFORMATION OFFICER REPORT

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

e-Prescribing:

As of March 27th, the I-STOP (Internet System for Tracking Over-Prescribing) law requires physicians, nurse practitioners, physician assistants, midwives, dentists, podiatrists, and optometrists ("prescribers") in New York State to

issue prescriptions electronically directly to a pharmacy, with limited exceptions. This new law requires electronic prescribing for all types of medications (controlled substances and non-controlled substances) dispensed at a pharmacy in New York.

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

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

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

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

Challenges:
Registration of prescribers continues to be a challenge. Email addresses of prescribers are required for non-controlled and controlled substance registration with DrFirst. All notifications, including passwords, will be sent directly to prescribers via this email address. Compliance with the use of HHC sponsored e-mail addresses by medical staff has been difficult. The Email address entered in QuadraMed is also captured on the visit summaries which eventually displays on the patient portal. A meeting with Salvatore Russo, HHC Counsel and his legal team was held regarding the use of personal email for e-Prescribing registration. Resolution of this issue is still pending. Hard tokens for two factor authentication (TFA) is a requirement for controlled substance e-Prescribing. There is a $35.00 cost per prescriber should HHC decide to provide each prescriber a hard token. With approximately 14,594 prescribers at $35 each will result in a cost of $507,500 which is cost prohibitive. In contrast, a soft token TFA can be downloaded to smart devices, i.e. iPhones, Blackberry and/or iPad, without cost. This is a highly recommended form of TFA, however, prescribers have legal concerns regarding the use of their personal devices. These concerns were also discussed with Mr. Russo and his team. Resolution of this issue is still pending. Education and awareness on the adoption of the new process remains a considerable challenge. The staggering number of prescribers in the 21 facilities impacts the capacity for user training and support.

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

Meaningful Use (MU) Update:

As of January 2015, out of 2115 hospitals across the United States that were eligible to attest for Meaningful Use (MU) Stage2 Year 1, 1814 or 77% have attested. To date, HHC has received additional Medicare MU funds in the amount of $3,262,113.21 for a total payment of $ 8,040,786.03. Medicaid attestations were submitted in January with MU funds still pending. We are expecting an additional $8 million in 4-6 weeks. For MU Stage2 Year 2, CMS has announced that

it will issue a rule in spring easing the requirements for 2015. CMS plans to reduce the reporting period to ninety (90) days instead of a full year. It also intends to shift hospitals to a calendar year reporting period to provide hospitals with more time to adopt the 2014 version for a certified Electronic Medical Record. For MU Stage 3, the Proposed Rule is still under review.

Epic EMR Implementation Program:

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

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

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

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

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

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

Over the next ninety (90) days, Clinical Information Systems will continue to conduct workgroup sessions with the various SMEs across HHC. The Leadership Activation Team meetings at the Queens Health Network are slated to reconvene. In the late spring, EITS is planning an "ICIS Day in the Life" sessions for facilities to participate in. Going forward, EITS each month will either be reporting or presenting different aspects of the Epic EMR program to the Committee in preparation for our go-live in the first quarter of Calendar Year 2016.

INFORMATION ITEMS:

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

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

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

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

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

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

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

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

Our PPS Project Scores: Subjective Scores: OneCity Health scored at least 94% on each project's subjectively-score sections, except for project 2.a.i, (IDS), for which it received 82% of possible subjective points. The weighted average score for these sections is 96.92. Objective Scores: OneCity Health received between 70% and 77% for each project's objectively-scored sections, with one exception, Project 11, for which we received 94%. The weighted average score for these sections is 75.72.

Independent Assessor Scoring Take-Aways: We scored very well on the organization-wide score and the project-subjective score, and received lower scores on the speed and scale scores – consistent with all other PPSs in the City and the State. We made a deliberate decision to be conservative on speed and scale, given the size and complexity of our PPS. We remain convinced that our conservative approach will help us maximize our performance. We will not know final valuation until Project 11 (project for engagement of uninsured and Medicaid non-and low-utilizers) bonus points are awarded and valuation attribution is released in mid-March.

There being no further business, the meeting was adjourned at 10:30 AM.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
March 12, 2015

Total plan enrollment as of February 1, 2015 was 466,261. Breakdown of plan enrollment by line of business is as follows:

Medicaid	409,748
Child Health Plus	12,078
Family Health Plus	7
MetroPlus Gold	3,420
Partnership in Care (HIV/SNP)	4,836
Medicare	8,599
MLTC	824
QHP	26,001
SHOP	736
FIDA	12

Despite open enrollment being almost two months shorter, with much less publicity for this period, Metro Plus marketing staff submitted approximately the same number of applications for health insurance this year when compared to last, approximately 32,000. Two thirds of these applicants were for Medicaid and one third qualify for QHP. Further while most of these are MetroPlus applications, our staff is required to submit applications for those who choose other plans.

I would like to inform this committee of a few new regulations from the New York State of Health.

First, the Open Enrollment period was extended to February 28th, 2015, for the persons who were unable to complete the enrollment process before the February 15th deadline. Plan facilitated enrollers are allowed to complete the applications via telephone. Effective date for the individuals enrolling during this extended period will be April 1, 2015.

Second, New York State of Health announced a Special Enrollment period (SEP) for individuals and families who had to pay a federal penalty for2014 and had not been aware of or understood that they would have to pay a penalty for not having health insurance coverage. The SEP will start on March 1st and end on April 30th, 2015. Consumers who do not enroll during this period and do not meet the criteria for other SEPs will not be able to purchase coverage for the remainder of 2015 and may be subject to a federal tax penalty when they file their 2015 federal income taxes.

The State also proposed to include in the NYSOH application language emphasizing the importance of selecting a PCP for Medicaid Managed Care (MMC) and Child Health Plus (CHP) with a hyperlink to the plan's provider network page. PCP selection would not be possible at the time of application, but would be prompted once the member is enrolled and becomes active.
In addition, the Affordable Care Act calls for a new product called the Basic Health Plan (BHP). This new line of business is applicable only to the Aliessa population starting in April 2015 (the Aliessa decision made the full range of New York's Medicaid program available to all lawfully

present legal immigrants) and it provides a new option for states to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from zero to 200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage is in lieu of Marketplace coverage. States operating a BHP enter into contracts to provide standard health plan coverage to eligible individuals. Eligible individuals in such a state could enroll in BHP coverage and would not have access to coverage through the Health Insurance Marketplace. The amount of the monthly premium and cost sharing charged to eligible individuals enrolled in a BHP may not exceed the amount of the monthly premium and cost sharing that an eligible individual would have paid if he/she were to receive coverage from a QHP through the marketplace. A state that operates a BHP will receive federal funding equal to 95% of the premium tax credit (PTC) and the cost-sharing reductions (CSR) that would have been provided to (or on behalf of) eligible individuals.

Enrollment in BHP will be open all year. Applications for BHP coverage in 2016 will be processed starting October 1, 2015. Federal regulations require that BHP enrollees have a choice of insurance plan in each county of the state. Applicants will have the ability to choose to participate in the commercial QHP Individual market, Small Business Marker, or the BHP, or any combination. The Aliessa population will have additional benefits for non-emergency transportation, non-prescription drugs, orthotic devices, orthopedic footwear, and vision care. Adult benefits will be available to BHP as follows: immigrants at or below 138% who previously qualified for Medicaid will receive additional dental benefits through BHP, and all other enrollees will be able to purchase stand-alone dental plans.

Starting July 1, 2015, plans will be expected to contract for urgent and routine primary care with School Based Health Center (SBHC) sponsoring entities. SBHC sponsors will have to contract with the Plan's oral health and behavioral health vendors in addition to the Plan. Reproductive Health Services would remain carved out of the SBHC. Providers will bill fee-for-service if the primary visit is for reproductive health.

Regarding transgender related benefits and care, the Department of Health is proposing the following new services: cross-sex hormone therapy and surgical gender reassignment, including post-transition care. These benefits apply to the Medicaid population, while approval for the CHP population is pending.

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

February-2015

		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Total Members	Prior Month	465,796	464,299	466,862	466,918	468,435	472,847	467,844
	New Member	17,783	20,504	19,060	19,832	19,976	26,446	16,252
	Voluntary Disenroll	1,504	1,973	1,495	1,636	1,685	2,007	1,834
	Involuntary Disenroll	17,776	15,968	17,509	16,679	13,879	29,442	16,001
	Adjusted	136	187	-250	423	375	2,621	0
	Net Change	-1,497	2,563	56	1,517	4,412	-5,003	-1,583
	Current Month	464,299	466,862	466,918	468,435	472,847	467,844	466,261
Medicaid	Prior Month	378,208	381,264	387,246	391,220	396,415	404,467	411,692
	New Member	15,745	18,147	16,747	17,576	18,041	20,563	13,329
	Voluntary Disenroll	1,211	1,622	1,198	1,283	1,402	1,123	1,297
	Involuntary Disenroll	11,478	10,543	11,575	11,098	8,587	12,215	13,976
	Adjusted	139	201	-241	442	394	2,375	0
	Net Change	3,056	5,982	3,974	5,195	8,052	7,225	-1,944
	Current Month	381,264	387,246	391,220	396,415	404,467	411,692	409,748
Child Health Plus	Prior Month	11,695	11,678	11,822	12,045	12,202	12,303	12,140
	New Member	489	680	826	695	705	821	477
	Voluntary Disenroll	51	68	49	96	96	526	136
	Involuntary Disenroll	455	468	554	442	508	458	403
	Adjusted	2	-2	-1	-1	5	217	0
	Net Change	-17	144	223	157	101	-163	-62
	Current Month	11,678	11,822	12,045	12,202	12,303	12,140	12,078
Family Health Plus	Prior Month	17,555	14,964	12,411	9,425	5,891	3,533	84
	New Member	35	23	23	14	12	1	0
	Voluntary Disenroll	53	65	58	34	25	17	0
	Involuntary Disenroll	2,573	2,511	2,951	3,514	2,345	3,433	77
	Adjusted	1	0	1	3	0	7	0
	Net Change	-2,591	-2,553	-2,986	-3,534	-2,358	-3,449	-77
	Current Month	14,964	12,411	9,425	5,891	3,533	84	7

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

February-2015

		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
HHC	Prior Month	3,512	3,520	3,549	3,445	3,456	3,470	3,618
	New Member	60	56	67	30	58	178	0
	Voluntary Disenroll	0	0	0	0	0	0	170
	Involuntary Disenroll	52	27	171	19	44	30	28
	Adjusted	4	4	10	9	16	45	0
	Net Change	8	29	-104	11	14	148	-198
	Current Month	3,520	3,549	3,445	3,456	3,470	3,618	3,420
SNP	Prior Month	5,252	5,198	5,095	5,014	4,959	4,945	4,906
	New Member	73	58	49	61	61	44	52
	Voluntary Disenroll	40	78	36	54	29	29	43
	Involuntary Disenroll	87	83	94	62	46	54	79
	Adjusted	1	0	0	-5	-7	-3	0
	Net Change	-54	-103	-81	-55	-14	-39	-70
	Current Month	5,198	5,095	5,014	4,959	4,945	4,906	4,836
Medicare	Prior Month	8,140	8,245	8,340	8,388	8,469	8,541	8,568
	New Member	362	336	306	359	291	443	295
	Voluntary Disenroll	149	138	154	168	133	312	188
	Involuntary Disenroll	108	103	104	110	86	104	76
	Adjusted	-4	-4	-4	-4	-5	-15	0
	Net Change	105	95	48	81	72	27	31
	Current Month	8,245	8,340	8,388	8,469	8,541	8,568	8,599
Managed Long Term Care	Prior Month	604	627	673	723	774	808	814
	New Member	39	58	66	84	55	39	41
	Voluntary Disenroll	0	0	0	1	0	0	0
	Involuntary Disenroll	16	12	16	32	21	33	31
	Adjusted	-2	-2	-2	-2	-4	-1	0
	Net Change	23	46	50	51	34	6	10
	Current Month	627	673	723	774	808	814	824

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

February-2015

		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
QHP	Prior Month	40,183	38,120	37,012	35,931	35,529	34,010	25,300
	New Member	920	1,097	937	986	707	4,324	2,030
	Voluntary Disenroll	0	2	0	0	0	0	0
	Involuntary Disenroll	2,983	2,203	2,018	1,388	2,226	13,034	1,329
	Adjusted	-1	0	1	-3	-7	10	0
	Net Change	-2,063	-1,108	-1,081	-402	-1,519	-8,710	701
	Current Month	38,120	37,012	35,931	35,529	34,010	25,300	26,001
SHOP	Prior Month	647	683	714	727	740	770	719
	New Member	60	49	39	27	46	30	19
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	24	18	26	14	16	81	2
	Adjusted	-4	-10	-14	-16	-17	-14	0
	Net Change	36	31	13	13	30	-51	17
	Current Month	683	714	727	740	770	719	736
FIDA	Prior Month	0	0	0	0	0	0	3
	New Member	0	0	0	0	0	3	9
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	0	0	0	0	0	0	0
	Adjusted	0	0	0	0	0	0	0
	Net Change	0	0	0	0	0	3	9
	Current Month	0	0	0	0	0	3	12

Epic Implementation Clinical Signoff Overview

Medical and Professional Affairs/IT Committee
March 12th, 2015

Objectives

- **To demonstrate to clinical workgroup members, through a series of scenarios, major workflows that span multiple clinical settings.**
- **To provide clinical workgroup members with a final opportunity to provide comments on system design after build completion and before moving on to testing.**

Logistics

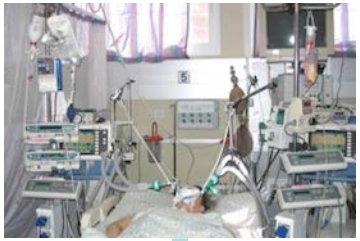
- **Only Subject Matter Experts (SMEs) who have been involved with clinical workgroups are invited to attend.**
- **Sessions are tentatively scheduled for May-June, 2015.**
- **Sessions will take place at the acute care hospital of each network and Health & Home Care Manhattan office to accommodate and minimize the disruption of SMEs' schedules.**
- **Representatives from each application team will be stationed outside of the sessions to document comments from the attendees about the demonstrated workflows.**
- **Comments will be categorized: *Patient Safety*, *Regulatory Requirements*, *Workflow-Critical*, *Future State*, *Nice-To-Have* and triaged accordingly.**

Sample Scenario

Emergency Department

- Victim of a construction site accident arrives at ED by ambulance
- Patient is triaged and assessed, trauma team is activated
- Patient receives blood transfusion and is intubated, then transferred to ICU

Medical ICU



- Patient receives interdisciplinary care in ICU
- Patient has a history of bipolar disorder and exhibits violence and paranoia
- Patient becomes medically stable and is transferred to IP Behavioral Health

IP Behavioral Health

- Patient engages in therapeutic activities; medications administered and education provided on managing condition
- Patient is discharged home with follow up plans

OP Behavioral Health

- Patient follows up at an Outpatient Behavioral Health Clinic

Preliminary Schedule

Hospital (Network)	Date
Queens (QHN)	Tuesday, May 19th
Elmhurst (QHN)	Wednesday, May 20th
North Central Bronx (NBX)	Tuesday, May 26th
Jacobi (NBX)	Wednesday, May 27th
Lincoln (Gens Plus)	Tuesday, June 2nd
Harlem (Gens Plus)	Wednesday, June 3rd
Metropolitan (SMN)	Tuesday, June 9th
Bellevue (SMN)	Wednesday, June 10th
Woodhull (NBN)	Tuesday, June 16th
Kings (CBN)	Wednesday, June 17th
Coney Island (SBN)	Thursday, June 18th
Health and Home Care	Tuesday, June 23rd

Next Steps

- **Finalize locations, dates and times by late March.**
- **Send out invitations to workgroup members by early April.**
- **Finalize presentations and workflows by mid-April.**
- **Conduct dress rehearsals by late April.**