AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

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

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES
January 12, 2015

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**
2015 Strategic Plan

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

INFORMATION ITEMS:

1. **DSRIP Planning and Implementation** — **DR. JENKINS**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: January 15, 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
Dave Chokshi, Assistant Vice President, Care Management
Paul Contino, Chief Technology Officer
Juliet Gaengan, Senior Director, Quality & Innovation
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
MeiChih Lin, Assistant Director, EITS
Patricia Lockhart, Secretary to the Corporation
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
Eric Orner, Director, Communication and Marketing
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
Jared Sender, Enterprise Information Technology Service
Diane E. Toppin, Senior Director, M&PA Divisional Administrator
Joyce Wales, Senior Assistant Vice President, Behavioral Health
Ross Wilson, Senior Vice President/Corporate Chief Medical Officer, Medical and Professional Affairs

FACILITY STAFF:

Gregory Almond, MD Chief Medical Officer (Acting)
Seth Diamond, Chief Operating Officer, MetroPlus Health Plan
Andreea Mera, Special Assistant, MetroPlus
David Hoffman, North Bronx Health Network
Anthony Rajkumar, Acting Executive Director, Metropolitan Hospital Center

OTHERS PRESENT

Mike Butler, OMB
Todd Cape, CFO, GSI Health
Scott Hill, Account Executive, OMB
LeRoy Jones, CEO, GSI Health
Sean Kelly, GSI Health
Amy Koizim, Director, GSI
Richard McIntyre, Siemens
Nick Pieshallin, Siemens
Kristyn Raffaele, Analyst, OMB
Dhruneanne Woodrooffe, Analyst OMB

MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, January 15, 2015

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 9:00 AM. The minutes of the December 11, 2014 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.

FLU

The flu season is in full swing across NYS and the Commissioner declared the flu season underway in December. The graphics that was provided is from state-wide data.

HHC's clinical services are able to manage the increased demands, particularly Emergency Departments and primary care clinics. As a consequence of the declaration of the flu season all non-vaccinated employees must wear a surgical mask until the flu season is over. Currently nearly 80% of employees are vaccinated, with >90% levels seen at Belvis, Cumberland, Gouverneur, SS McKinney, Morrisania, Queens Hospital and Seaview. Our goal is to further improve the vaccination rate at all of our sites, as it provides safe and effective protection for our patients and staff, against a flu epidemic**.**

Delivery System Reform Incentive Payment (DSRIP) Program

In December, HHC lodged a complex application for participation in the program as a PPS (Performing Provider System) lead. HHC had nearly 200 partners in our application, including SUNY through University Hospital Brooklyn. The applications from all PPSs will be made public soon, as they are assessed by an external group on behalf of NYS. Our team is now focused on the development of the required implementation plans for each project, as well as capital requests due to be submitted to NYS in February

Accountable Care Organization (HHC ACO)

The ACO now enters its 3rd performance year as of 2015. Facility ACO Leadership Teams continue to develop and improve their approaches to high-risk patient and population management as our track record lengthens and we continue to learn a great deal collectively from the experiences of each of our PCMH-based ACO teams.

The annual member meeting of the ACO was held in December 2014 and the Board membership was confirmed, including a new position for an NYU representative.

Consistent with the Medicare Shared Savings Program (MSSP) and the HHC ACO Board resolutions on distribution of shared savings, $1.2m will be paid to primary care physicians across HHC. Over the next month, the distribution will occur through the employer (affiliate) and will be in proportion to the number of "attributed patients" cared for by each facility. The average amount received by physicians is approximately $6000.

Ambulatory Care

During December, 280 frontline staff across our ambulatory care services received care coordination training through GNYHA. This is part of the ongoing development of care management capacity in the Patient Centered Medical Home (PCMH) model of primary care across HHC.

NY State Medicaid Collaborative Care Depression Program

Four facilities (Bellevue, Belvis, Morrisania and Renaissance) have been accepted to participate in the New York State Medicaid Collaborative Care Depression Program; an additional 10 facilities (Gouverneur, Coney Island, Elmhurst, Queens, Woodhull, Cumberland, Harlem, Jacobi, Lincoln, and Metropolitan) have been invited to apply to participate. This recognizes that these sites have met threshold performance standards set by the state, and will become eligible to bill for these services.

MetroPlus Health Plan, Inc.

On behalf of Arnold Saperstein, MD Executive Director, Seth Diamond of MetroPlus Health Plan Inc. presented to the Committee. Mr. Diamond informed the Committee that the total plan enrollment as of December 1, 2014 was 473,055. Breakdown of plan enrollment by line of business is as follows:

Medicaid	402,711
Child Health Plus	12,291
Family Health Plus	3,510
MetroPlus Gold	3,405
Partnership in Care (HIV/SNP)	4,945
Medicare	8,548
MLTC	810
QHP	36,086
SHOP	749

Attached are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

As we still find ourselves in the Open Enrollment Period, complete information on membership growth is not yet available. However, as of the date of this report, the most recent updates are as follows: overall, for QHP and Medicaid, from November 15th to December 27th, 2014, we have assisted in the submission of 15,898 applications. Over the six-week time period we have averaged 2,649 submitted applications per week. Invoices have been sent to all the potential QHP members, and payment must be received in order to effectuate their enrollment.

Of our current 36,086 QHP members, many have been renewed automatically by the state. Approximately 7,800 of those members received notification by the state that they are required to confirm their financial status on the state website, yet they have not done so. Those members will temporarily lose their tax credits, and are being billed for the full premium, together with outreach from us of the need to visit the website to confirm their status. We are concerned about the confusion this will cause, and have our customer services staff ready to assist.

MetroPlus continues the collaboration with HHC in an effort to increase membership referrals. Our Learning and Organizational Development team has been working with the Revenue Management

Department in Central Office to coordinate Marketplace Assister training of the HHC HCIs. The first training session of 30 HCIs took place the first week in January. In addition, our Call Center and Marketing Department are working closely with HHC to increase the number of enrollments for self-pay patients who may qualify for our Exchange line of business.

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

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

MetroPlus continues to move forward with implementing the delegation of all Behavioral Health and Substance Use Disorder services to Beacon Health Strategies. Effective January 1, 2015, Beacon is fully delegated for the FIDA line of business. All other lines of business will follow and be fully delegated effective February 1, 2015. Beacon is still in the process of contracting for Behavioral Health and Substance Abuse services with the HHC system through HHC's Office of Managed Care. Members in all lines of business have been sent letters of notification explaining MetroPlus' delegation of functions to Beacon. Additionally, members who have terminating providers will receive "Transitional Care" letters. 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. At issue is the fact that MetroPlus would be the only plan to be awarded two separate licenses. The decision related to the license was expected by December 1st; however, the issue is still being reviewed by SDOH. MetroPlus is continuing ongoing meetings with State liaisons to achieve all HARP readiness initiatives. At this time the State is advising that the SSI Carve-In and HARP line of business will be implemented April 1, 2015. Internally, MetroPlus continues its work on the infrastructure to make both the carve-out to Beacon and the new HARP line of business fully operational.

ACTION ITEM:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with GSI Health, Inc. to provide a Care Coordination and Management Solution (CCMS). This solution will serve as the foundational population health management, coordination, communication, collaboration, documentation tracking, and registration system for the Corporation's overall Delivery System Reform Incentive Payment (DSRIP) strategy and several programs operated by the Corporation in conjunction with its DSRIP program. The contract shall be for a period of five years with two, one-year options to renew, exercisable solely by the Corporation, in an amount not to exceed $35,441,897 (including a contingency of $1,177,918 for additional software services as needed).

Lauren Johnston, Senior Assistant Vice President of Patient Centered Care presented to the Committee the request for an approval to enter into a contract with GSI Health, Inc. Ms. Johnston presented to the need to enter into a contract for an integrated web base platform to provided Care Coordination and Care Management to an enormously large group of patients. The need is urgent for our Health Home to be able to accommodate the anticipated patient population expansion due to the impact of HARP, adopted Health Homes in the area, and demands from the state to include patients in HHC Health Home. The Health Home program is specific to a Medicaid payment process. The existing payment methodology cannot accommodate the anticipated increase patient capacity. Changes in the payment methodology does not allow for payment of the existing legacy program that has been in the system for quite some time. Once the new platform is initiated the legacy program will not generate any revenue. This new system will also be transformational as a result of the DSRIP and our future PPS will create an enormous amount of patients -- the Health Home population could grow to as much as 2 million patients. We need a web base to track all our patients within HHC and our partner community base organizations. The care coordination and management solution is what has become the true integrated healthcare delivery strategy. When looking at the procurement method there were 8 vendors that expressed interest and 4 vendors who meet the minimum qualifications. GSI was the chosen vendor; they have been very successful with10 other Health Homes in the State.

Resolution was approved for the full Board's consideration.

INFORMATION ITEMS

Bert Robles, Senior Vice President, Information Systems provided the Committee with the e-Prescribing Initiative and Meaningful Use Update:

e-Prescribing Initiative Update:

Mr. Robles updated the Committee members on an important initiative and New York State mandate, e-Prescribing (eRx). New York State passed legislation to effectively curtail forged and counterfeit prescriptions, track patterns of potential prescription misuse and improve patient safety. The Internet System for Tracking Over-Prescribing (I-STOP) law mandates that effective March 27, 2015; all prescriptions issued in New York State are done electronically. We'd like to take this opportunity to update you on our progress as well as the challenges we face in order to meet the March deadline.

We have been working closely with the Credentialing and the Graduate Medical Education (GME) offices to obtain the accurate number of prescribers that will be affected by this mandate. The prescriber number has increased to 14,594 as compared to 7,000 as previously reported. This twofold increase has impacted our capacity and poses a risk in meeting the deadline. Please note each prescriber

has to be registered first before they can electronically prescribe non-controlled and controlled substances. In addition, they must be trained on how to use this new eRx function in Quadramed.

As of today, ninety percent (90%) of prescribers are already registered for non-controlled e-prescribing. The QCPR team with Credentialing and GME offices is performing this task on behalf of the prescribers.

However, fewer than five percent (5%) have registered with the Electronic Prescription for Controlled Substances (EPCS). To electronically prescribe controlled substances: i) prescribers must complete identity proofing and ii) obtain a two-factor authentication as defined in the federal requirements. Additionally, prescribers are required to register their certified EPCS software application which is DrFirst, with the Bureau of Narcotic Enforcement (BNE). Unfortunately, no one else can perform this registration on their behalf.

To assist our prescribers with this registration, we launched an Awareness campaign on e-prescribing mandate, requirements and deadline. We also visited facilities and shared with the administrative and clinical leadership the implementation plan, risks and challenges. Flyers were distributed and staff received "e-prescribing now, ask me how" pins to wear.

Kings County Hospital Center was chosen as the pilot site for e-prescribing. Due to its success, the implementation pilot has been expanded to include more prescribers. Dr. Peter Peacock from Kings County Hospital Center has been spearheading this initiative and has been actively involved in developing training materials for the enterprise based on actual experiences gained from the pilot.

User training has started and will continue as needed. At the same time, twenty-one (21) facilities accounting for 14,549 prescribers are transitioning for implementation with some facilities going live as early as January 20th. Our goal is to complete this implementation enterprise-wide by the end of February 2015.

The Credentialing and GME offices have been kept informed and apprised of our progress. They are also encouraged to familiarize themselves with these federal requirements so to avoid delays and disruptions to patient care as they provision new practitioners in the future.

As we are learning, discovering and adapting to these new workflows, there are areas of risk which we are monitoring closely in order to remain on schedule.

For example, we have a subset of niche systems that will not have the e-prescribing capability to meet this mandate. We have plans for making them compliant; however, they may not meet the current deadlines.

In addition, we are faced with the challenge of successfully delivering substantial patient education so that patients understand the mandate as well as how their prescriptions will be filled going forward. Patient engagement and awareness on e-prescribing remains key in order to achieve the transformation to the new way of fulfilling prescriptions.

Similarly, Providers must understand and be able to transform their current workflows in order to meet the mandate. Due to the large number of prescribers our capacity for user training and support remains challenged.

These risks and concerns are being discussed and monitored closely by the members of the eRx Steering Committee which is co-chaired by Dr. Machelle Allen and Maricar Barrameda.

Meaningful Use (MU) Update:

With regards to Meaningful Use (MU) Stage 2 Year 1, as of December 26, 2014, HHC has received Medicare MU funds for six (6) facilities totaling $4,778,672.82. The remaining five (5) facilities have been approved for payment totaling $3,262,388.21. Medicaid attestations are still pending due to some technical issues at the state level and the deadline for submission has been pushed back to January 31, 2015.

MU Stage 2 Year 2 is ongoing and compliance is being closely monitored.

For MU Stage3, the Proposed Rule is expected sometime this winter. This Proposed Rule is currently under review by the Office of Management and Budget and it is one of the last steps prior to its publication in the Federal Register. The focus for the Proposed Rule for Stage 3 is on improving health outcomes and furthering interoperability.

Since our last report, there has been no significant change for Eligible Professionals. Eligible professionals can participate for six (6) years and the participation years do not need to be concurrent. Incentive payments for eligible professionals remain higher under the Medicaid EHR incentive payments totaling up to $63,750 over six years.

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

Management Indicator Report # 1

For Enrollment Month 201501

Indicator #1A for Enrollment Month: January 2015

Disenrollments To Other Plans

		Enrollment Mont			Twelve Months Period		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOLUNTARY		30	30	29	402	431
	VOLUNTARY	1	44	45	55	657	712
Affinity Health Plan	**TOTAL**	**1**	**74**	**75**	**84**	**1059**	**1143**
	INVOLUNTARY	2	67	69	32	736	768
	UNKNOWN		1	1		2	2
	VOLUNTARY	2	68	70	39	1068	1107
Amerigroup/Health Plus/CarePlus	**TOTAL**	**4**	**136**	**140**	**71**	**1806**	**1877**
	INVOLUNTARY	4	192	196	106	2087	2193
	VOLUNTARY	9	276	285	201	3406	3607
Fidelis Care	**TOTAL**	**13**	**468**	**481**	**307**	**5493**	**5800**
	INVOLUNTARY	4	326	330	137	3307	3444
	VOLUNTARY	4	516	520	230	5915	6145
Health First	**TOTAL**	**8**	**842**	**850**	**367**	**9222**	**9589**
	INVOLUNTARY		32	32	7	338	345
	VOLUNTARY	1	34	35	19	435	454
HIP/NYC	**TOTAL**	**1**	**66**	**67**	**26**	**773**	**799**
	INVOLUNTARY	6	55	61	22	552	574
	VOLUNTARY		52	52	26	561	587
United Healthcare of NY	**TOTAL**	**6**	**107**	**113**	**48**	**1113**	**1161**
	INVOLUNTARY	1	29	30	21	269	290
	VOLUNTARY		18	18	12	163	175
Wellcare of NY	**TOTAL**	**1**	**47**	**48**	**33**	**432**	**465**
	INVOLUNTARY	19	762	781	397	8061	8458
	UNKNOWN		1	1	10	6	16
	VOLUNTARY	17	1028	1045	608	12336	12944
Disenrolled Plan Transfers	**TOTAL**	**36**	**1791**	**1827**	**1015**	**20403**	**21418**
	INVOLUNTARY	1	29	30	40	628	668
	VOLUNTARY		40	40	4	445	449
Disenrolled Unknown Plan Transfers:	**TOTAL**	**1**	**69**	**70**	**44**	**1073**	**1117**
	INVOLUNTARY	662	11885	12547	10181	128444	138625
	UNKNOWN		9	9	153	278	431
	VOLUNTARY		29	29	21	962	983
Non-Transfer Disenroll Total:	**TOTAL**	**662**	**11923**	**12585**	**10355**	**129684**	**140039**
	INVOLUNTARY	682	12676	13358	10618	137133	147751
	UNKNOWN		10	10	163	285	448
	VOLUNTARY	17	1097	1114	633	13743	14376
Total MetroPlus Disenrollment:	**TOTAL**	**699**	**13783**	**14482**	**11414**	**151161**	**162575**

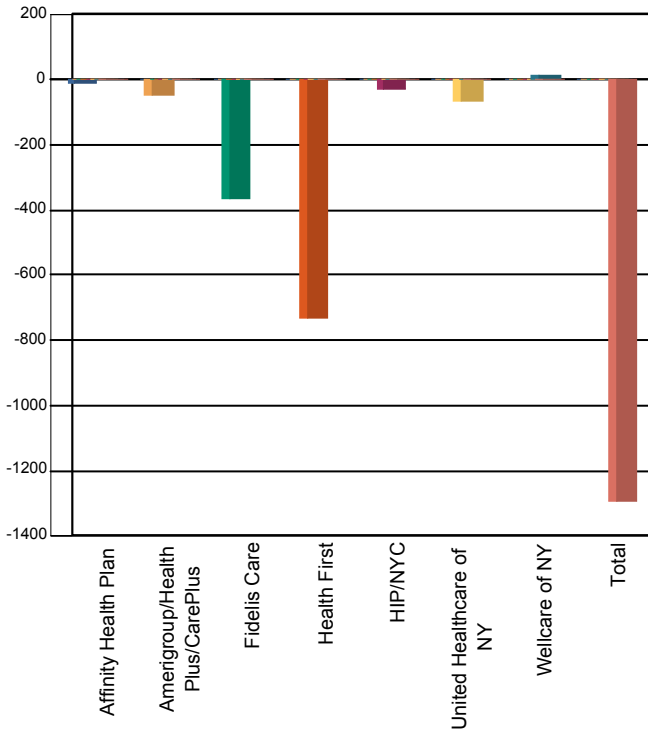
New MetroPlus Members Disenrolled From Other Plans

	FHP	MCAD	Total	Y FHP	Y MCAD	Y Total
Affinity Health Plan		63	63	50	1,204	1,254
Amerigroup/Health Plus/CarePlus		92	92	65	1,662	1,727
Fidelis Care		113	113	66	1,615	1,681
Health First		118	118	60	1,761	1,821
HIP/NYC		36	36	10	664	674
United Healthcare of NY		44	44	29	734	763
Wellcare of NY		64	64	45	850	895
Total		530	530	325	8,490	8,815
Unknown/Other (not in total)		6,006	6,006	3,482	66,207	69,689

Net Difference

	Enrollment Month			Twelve Months Period		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan		-11	-12	-34	145	111
Amerigroup/Health Plus/CarePlus		-44	-48	-6	-144	-150
Fidelis Care		-355	-368	-241	-3,878	-4,119
Health First		-724	-732	-307	-7,461	-7,768
HIP/NYC		-30	-31	-16	-109	-125
United Healthcare of NY		-63	-69	-19	-379	-398
Wellcare of NY		17	16	12	418	430
Total		-1,261	-1,297	-690	-11,913	-12,603

Enroll Month Net Transfers (Known)



MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2015

Other Plan Name	Category	2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
AETNA	INVOLUNTARY	1	2	1	4	0	3	0	3	1	1	1	5	0	6	0	8	1	3	0	3	0	6	1	3	53
	VOLUNTARY	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	TOTAL	1	2	1	4	0	3	0	3	1	2	1	5	0	6	0	8	1	3	0	3	0	6	1	3	54
Affinity Health Plan	INVOLUNTARY	3	29	1	3	1	16	11	90	0	19	5	93	3	20	1	21	2	18	0	41	2	22	0	30	431
	VOLUNTARY	7	52	10	76	11	104	0	1	4	79	0	0	7	52	6	93	6	52	3	61	0	43	1	44	712
	TOTAL	10	81	11	79	12	120	11	91	4	98	5	93	10	72	7	114	8	70	3	102	2	65	1	74	1,143
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	5	54	1	13	0	25	12	165	1	44	6	128	0	46	0	53	0	44	1	51	4	46	2	67	768
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	2
	VOLUNTARY	1	74	9	143	6	181	0	0	10	148	0	1	5	80	2	115	0	67	1	98	3	93	2	68	1,107
	TOTAL	6	128	10	156	6	206	12	165	11	192	6	130	5	126	2	168	0	111	2	149	7	139	4	136	1,877
BC/BS OF MNE	INVOLUNTARY	0	5	2	6	0	9	1	6	1	12	1	10	1	11	0	20	1	8	2	22	1	7	1	16	143
	VOLUNTARY	0	0	0	1	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0	2	0	2	0	3	12
	TOTAL	0	5	2	7	1	10	1	6	2	13	1	10	1	11	0	20	1	8	2	24	1	9	1	19	155
CIGNA	INVOLUNTARY	1	4	0	4	0	3	0	5	0	1	0	1	1	4	0	0	0	0	0	4	0	0	0	0	28
	VOLUNTARY	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	TOTAL	1	4	1	4	0	3	0	5	0	1	0	1	1	4	0	0	0	0	0	4	0	0	0	0	29
Fidelis Care	INVOLUNTARY	19	191	0	30	2	52	48	429	1	101	20	395	5	133	3	147	4	141	0	166	0	110	4	192	2,193
	UNKNOWN	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	3
	VOLUNTARY	8	162	41	404	35	454	0	0	42	416	0	0	10	315	22	404	16	302	11	332	7	341	9	276	3,607
	TOTAL	27	354	41	434	37	506	48	429	44	517	20	395	15	448	25	551	20	443	11	498	8	451	13	468	5,803

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2015

		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
GROUP HEALTH INC.	INVOLUNTARY	0	6	0	4	0	4	1	4	0	3	0	7	0	4	1	4	0	2	0	3	0	3	0	4	50
	VOLUNTARY	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	3
	TOTAL	0	6	0	4	1	4	1	4	0	3	0	7	0	4	1	6	0	2	0	3	0	3	0	4	53
Health First	INVOLUNTARY	32	309	1	46	2	90	41	696	9	185	26	658	1	179	5	193	6	201	3	251	7	173	4	326	3,444
	UNKNOWN	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	1	0	1	1	1	0	0	0	0	6
	VOLUNTARY	9	275	47	632	48	758	0	2	39	749	0	0	25	521	18	732	18	519	12	562	10	649	4	516	6,145
	TOTAL	41	584	48	678	50	848	41	698	49	934	26	658	27	700	23	926	24	721	16	814	17	822	8	842	9,595
HEALTH INS PLAN OF GREATER NY	INVOLUNTARY	0	2	1	1	0	2	0	1	0	0	0	3	0	3	0	1	0	3	1	2	0	2	0	2	24
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	2
	TOTAL	0	2	1	1	0	2	0	1	0	0	0	4	0	3	0	1	0	4	1	2	0	2	0	2	26
HIP/NYC	INVOLUNTARY	1	33	1	4	0	14	4	56	0	21	1	71	0	18	0	21	0	23	0	24	0	21	0	32	345
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	2	39	2	55	5	80	0	1	2	58	0	0	1	33	2	37	2	37	1	33	1	28	1	34	454
	TOTAL	3	72	3	59	5	94	4	57	2	79	1	71	1	51	3	58	2	60	1	57	1	49	1	66	800
OXFORD INSURANCE CO.	INVOLUNTARY	0	0	0	0	1	1	1	2	0	0	1	1	1	3	0	6	0	3	0	3	0	1	0	3	27
	VOLUNTARY	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3
	TOTAL	0	0	0	0	1	2	1	2	0	1	1	1	1	3	0	6	0	3	0	3	0	1	0	4	30
UNION LOC. 1199	INVOLUNTARY	7	21	0	8	2	5	3	12	1	4	1	8	0	4	1	1	0	1	1	2	0	3	0	3	88
	VOLUNTARY	0	0	1	12	5	15	0	0	1	10	0	0	1	14	8	23	5	7	1	9	0	7	0	16	135
	TOTAL	7	21	1	20	7	20	3	12	2	14	1	8	1	18	9	24	5	8	2	11	0	10	0	19	223

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2015

		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
United Healthcare of NY	INVOLUNTARY	1	48	0	10	1	24	3	86	1	33	6	70	0	39	1	43	0	52	2	50	1	42	6	55	574
	UNKNOWN	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2
	VOLUNTARY	2	30	3	99	8	82	0	1	7	65	0	0	2	39	1	63	3	38	0	32	0	60	0	52	587
	TOTAL	3	78	3	109	9	106	3	87	9	98	6	70	3	78	2	106	3	90	2	82	1	102	6	107	1,163
Wellcare of NY	INVOLUNTARY	2	17	2	1	0	16	1	25	2	18	9	42	1	10	0	29	1	27	0	35	2	20	1	29	290
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	VOLUNTARY	2	9	2	16	1	20	0	0	0	12	0	0	0	26	3	21	3	14	1	13	0	14	0	18	175
	TOTAL	4	26	4	17	1	36	1	25	2	30	11	42	1	36	3	50	4	41	1	48	2	34	1	47	467
Disenrolled Plan Transfers	INVOLUNTARY	72	721	10	134	9	264	126	1,580	17	442	77	1,492	13	480	12	547	15	526	10	657	17	456	19	762	8,458
	UNKNOWN	0	1	0	0	0	0	0	0	3	0	2	1	2	0	1	1	0	1	1	1	1	0	0	1	16
	VOLUNTARY	31	641	116	1,438	121	1,696	0	5	106	1,540	0	2	51	1,080	62	1,490	53	1,037	30	1,142	21	1,237	17	1,028	12,944
	TOTAL	103	1,363	126	1,572	130	1,960	126	1,585	126	1,982	79	1,495	66	1,560	75	2,038	68	1,564	41	1,800	39	1,693	36	1,791	21,418
Disenrolled Unknown Plan Transfers	INVOLUNTARY	2	76	1	27	8	29	4	71	4	53	5	128	1	33	1	59	3	35	7	58	3	30	1	29	668
	UNKNOWN	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	0	19	1	39	0	32	0	10	0	54	0	18	1	42	0	51	2	62	0	40	0	38	0	40	449
	TOTAL	2	95	2	66	8	61	4	81	4	108	5	146	2	75	1	110	5	97	7	98	3	68	1	69	1,118
Non-Transfer Disenroll Total	INVOLUNTARY	741	11,883	793	10,699	1,012	11,450	950	11,436	860	10,582	850	10,498	799	10,903	778	9,869	1,064	10,661	1,302	10,694	370	7,884	662	11,885	138,625
	UNKNOWN	2	6	2	1	13	13	14	12	22	15	29	22	34	45	10	48	4	53	23	40	0	14	0	9	431
	VOLUNTARY	0	46	2	80	2	88	0	47	2	83	0	107	1	90	3	80	3	97	4	97	4	118	0	29	983
	TOTAL	743	11,935	797	10,780	1,027	11,551	964	11,495	884	10,680	879	10,627	834	11,038	791	9,997	1,071	10,811	1,329	10,831	374	8,016	662	11,923	140,039

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2015

		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Total MetroPlus Disenrollment	**INVOLUNTARY**	815	12,680	804	10,860	1,029	11,743	1,080	13,087	881	11,077	932	12,118	813	11,416	791	10,475	1,082	11,222	1,319	11,409	390	8,370	682	12,676	147,751
	UNKNOWN	2	7	2	1	13	13	14	12	25	16	31	23	36	45	11	49	4	54	24	41	1	14	0	10	448
	VOLUNTARY	31	706	119	1,557	123	1,816	0	62	108	1,677	0	127	53	1,212	65	1,621	58	1,196	34	1,279	25	1,393	17	1,097	14,376
	TOTAL	848	13,393	925	12,418	1,165	13,572	1,094	13,161	1,014	12,770	963	12,268	902	12,673	867	12,145	1,144	12,472	1,377	12,729	416	9,777	699	13,783	162,575

MetroPlus Health Plan

New Member Transfer From Other Plans

	2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015	TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	
AETNA	3	13	1	6	1	6	0	3	1	4	0	3	0	8	0	6	0	7	1	9	0	8	7	87
Affinity Health Plan	5	114	6	106	10	119	8	113	7	112	1	88	3	95	5	102	2	87	1	87	2	118	63	1,254
Amerigroup/Health Plus/CarePlus	7	165	11	205	16	173	8	141	7	186	5	119	3	115	5	135	3	96	0	93	0	142	92	1,727
BC/BS OF MNE	4	19	2	14	5	14	0	6	0	11	0	7	0	19	0	30	0	25	0	49	0	45	28	278
CIGNA	1	9	2	3	2	7	0	3	0	5	0	6	0	0	0	1	0	4	0	1	0	1	1	46
Fidelis Care	3	130	15	151	10	188	5	163	10	144	9	146	6	115	6	138	2	117	0	97	0	113	113	1,681
GROUP HEALTH INC.	0	11	0	9	0	13	0	10	0	11	0	2	0	5	0	13	0	9	0	4	0	8	8	103
Health First	9	123	5	151	14	166	7	126	8	159	7	146	4	134	2	182	1	129	3	131	0	196	118	1,821
HEALTH INS PLAN OF GREATER N	0	14	1	7	0	8	0	2	0	5	0	3	0	8	0	8	1	3	0	10	0	15	10	95
HIP/NYC	2	69	1	60	2	74	2	64	1	72	2	43	0	36	0	53	0	55	0	50	0	52	36	674
OXFORD INSURANCE CO.	0	3	1	5	0	6	0	3	0	2	0	5	1	2	0	7	0	0	0	4	0	5	2	46
UNION LOC. 1199	3	18	3	6	8	27	4	19	1	21	3	8	2	12	1	18	0	17	2	3	0	6	14	196
United Healthcare of NY	7	77	10	72	4	92	3	56	4	66	0	54	0	43	0	57	0	55	0	64	1	54	44	763
Unknown Plan	1,111	6,298	1,138	5,655	946	7,268	161	4,756	72	6,032	14	4,724	9	4,364	5	5,219	14	4,808	4	5,170	8	5,907	6,006	69,689
Wellcare of NY	5	98	11	82	9	122	6	103	6	82	1	52	3	52	2	57	1	48	0	37	1	53	64	895
TOTAL	1,160	7,161	1,207	6,532	1,027	8,283	204	5,568	117	6,912	42	5,406	31	5,008	26	6,026	24	5,460	11	5,809	12	6,723	6,606	79,355

Report ID: MHP1268C
Report Run Date: 1/15/2015

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

January-2015

		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Total Members	Prior Month	468,020	465,723	464,163	466,672	467,199	468,583	473,919
	New Member	17,371	17,711	20,423	19,223	19,517	19,811	23,855
	Voluntary Disenroll	350	1,505	1,972	1,495	1,629	1,674	1,983
	Involuntary Disenroll	19,318	17,766	15,942	17,201	16,504	12,801	30,733
	Adjusted	18	53	43	-175	-893	1,503	0
	Net Change	-2,297	-1,560	2,509	527	1,384	5,336	-8,861
	Current Month	465,723	464,163	466,672	467,199	468,583	473,919	465,058
Medicaid	Prior Month	375,294	378,125	381,130	387,050	391,482	396,003	404,119
	New Member	15,110	15,686	18,076	16,917	17,262	17,908	19,023
	Voluntary Disenroll	128	1,212	1,621	1,196	1,279	1,393	1,097
	Involuntary Disenroll	12,151	11,469	10,535	11,289	11,462	8,399	12,695
	Adjusted	30	68	58	-150	-872	1,410	0
	Net Change	2,831	3,005	5,920	4,432	4,521	8,116	5,231
	Current Month	378,125	381,130	387,050	391,482	396,003	404,119	409,350
Child Health Plus	Prior Month	11,877	11,692	11,676	11,824	12,046	12,203	12,298
	New Member	446	489	681	826	693	699	628
	Voluntary Disenroll	56	51	68	51	95	95	533
	Involuntary Disenroll	575	454	465	553	441	509	470
	Adjusted	-8	-9	-13	-26	-34	7	0
	Net Change	-185	-16	148	222	157	95	-375
	Current Month	11,692	11,676	11,824	12,046	12,203	12,298	11,923
Family Health Plus	Prior Month	20,145	17,553	14,963	12,411	9,424	5,888	3,533
	New Member	42	35	23	23	14	11	0
	Voluntary Disenroll	0	53	65	58	34	25	17
	Involuntary Disenroll	2,634	2,572	2,510	2,952	3,516	2,341	3,439
	Adjusted	1	1	3	3	7	23	0
	Net Change	-2,592	-2,590	-2,552	-2,987	-3,536	-2,355	-3,456
	Current Month	17,553	14,963	12,411	9,424	5,888	3,533	77

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

January-2015

		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
HHC	Prior Month	3,437	3,511	3,516	3,545	3,435	3,447	3,454
	New Member	136	57	56	65	31	41	146
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	62	52	27	175	19	34	27
	Adjusted	-4	-4	-4	4	15	49	0
	Net Change	74	5	29	-110	12	7	119
	Current Month	3,511	3,516	3,545	3,435	3,447	3,454	3,573
SNP	Prior Month	5,230	5,252	5,198	5,096	5,015	4,967	4,956
	New Member	129	73	58	50	66	62	40
	Voluntary Disenroll	8	40	78	36	52	28	26
	Involuntary Disenroll	99	87	82	95	62	45	57
	Adjusted	0	0	0	-1	-2	11	0
	Net Change	22	-54	-102	-81	-48	-11	-43
	Current Month	5,252	5,198	5,096	5,015	4,967	4,956	4,913
Medicare	Prior Month	7,936	8,140	8,247	8,342	8,390	8,472	8,545
	New Member	462	363	336	306	359	292	440
	Voluntary Disenroll	158	149	138	154	168	133	310
	Involuntary Disenroll	100	107	103	104	109	86	82
	Adjusted	-1	-2	-1	-1	1	0	0
	Net Change	204	107	95	48	82	73	48
	Current Month	8,140	8,247	8,342	8,390	8,472	8,545	8,593
Managed Long Term Care	Prior Month	575	606	629	675	725	776	812
	New Member	44	39	58	66	84	56	38
	Voluntary Disenroll	0	0	0	0	1	0	0
	Involuntary Disenroll	13	16	12	16	32	20	35
	Adjusted	0	0	0	0	0	2	0
	Net Change	31	23	46	50	51	36	3
	Current Month	606	629	675	725	776	812	815

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

January-2015

		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
QHP	Prior Month	42,897	40,196	38,120	37,015	35,955	36,087	35,424
	New Member	952	909	1,087	932	981	697	3,530
	Voluntary Disenroll	0	0	2	0	0	0	0
	Involuntary Disenroll	3,653	2,985	2,190	1,992	849	1,360	13,872
	Adjusted	0	-1	-1	-5	-12	-10	0
	Net Change	-2,701	-2,076	-1,105	-1,060	132	-663	-10,342
	Current Month	40,196	38,120	37,015	35,955	36,087	35,424	25,082
SHOP	Prior Month	629	648	684	714	727	740	778
	New Member	50	60	48	38	27	45	7
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	31	24	18	25	14	7	56
	Adjusted	0	0	1	1	4	11	0
	Net Change	19	36	30	13	13	38	-49
	Current Month	648	684	714	727	740	778	729
FIDA	Prior Month	0	0	0	0	0	0	0
	New Member	0	0	0	0	0	0	3
	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	0	3
	Current Month	0	0	0	0	0	0	3

MetroPlus Health Plan

Strategic Plan - 2015

December 24, 2014

Strategic Plan - 2015

Our Strategic Plan is to increase market share while maintaining fiscal soundness, and for the plan to be viewed as the #1 Health Plan by our customers: members, providers, our staff, HHC, government and other external entities.

Strategic Plan - 2015

The foundation of our 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

Strategic Plan - 2015

1. **Increase the total Growth and Development of the Plan**
   - Improve and increase the collaboration between MetroPlus Marketing and Network Relations staff, and HHC HCIs to maximize member referrals.
   - Identify and outreach to new eligible populations.
   - Develop and implement strategies to improve members' experience and increase member satisfaction.
   - Refine processes and services that enhance retention and recertification of existing members.
   - Continuously work with providers to improve provider satisfaction.

Strategic Plan - 2015

- Engage in focused advertising utilizing print, subway/bus, radio, and television media.
- Increase and enhance electronic media sources such as Facebook and Twitter.
- Maximize the benefit of the strategically located Brooklyn and Queens offices.
- Continue development of attractive Exchange products at competitive pricing for 2016.

Strategic Plan - 2015

- Successfully implement the Fully-Integrated Dual Advantage (FIDA) program for the Dual Eligible Long Term Care members as of January 1, 2015.
- Successfully complete the certification process for the Health and Recovery Plan (HARP) by April 2015 to both better serve and expand the severely mentally ill population.

Strategic Plan - 2015

- Complete network development and application to expand license to Staten Island.
- Complete assessment and develop benefit program to offer MetroPlus to all NYC employees via the Office of Labor Relations.
- The 2015 calendar year-end membership target number is 520,000.

Strategic Plan - 2015

2. Maintain Financial Stability to provide care of our members by doing the following:

- Monitor proposed and final budget and rate setting approaches; provide feedback to all appropriate stakeholders.
- Achieve 2015 revenue and expense budget targets.
- Reinforce the need for complete coding accuracy and submission of data in order to maximize revenue based on member acuity.
- Enhance Data Analytics to maximize ability to manage utilization and quality data, and to develop models for evidence-based patient care strategies and value based provider payment modules to meet the new healthcare market challenges.
- Develop potential Value Based Purchasing methodologies.

Strategic Plan - 2015

- Ensure that medical dollars are used effectively:
  - Reduce ER utilization, use of Out-of-Network facilities, unnecessary hospitalizations and readmissions by enhancing the effectiveness of utilization and management strategies.
  - Transition (from CareStepp) to CareConnect for the Utilization Management platform.
  - Continue development and enhancement of the DRG validation process.

Strategic Plan - 2015

- Implement the Beacon contract to improve the care management and coordination of the plan's behavioral health population.
- Successfully integrate nursing home population into Medical Management Services.

- Utilize CVS Caremark Pharmaceutical Benefit Management data and services to maximize efficiencies of drug utilization.

Strategic Plan - 2015

3. Improve Medical Outcomes for Members:

- Re-achieve a #1 ranking as a Medicaid Managed Care Health Plan in NYC, based on indicators chosen by the NYSDOH, including QARR.
- Improve Medicare Star Ratings to at least a level 4 for the coming year.
- Align case management with Quality goals and outcomes to improve performance on:
  - Follow-up after mental illness
  - Post-Partum care
  - Reducing unnecessary hospitalizations
  - Reducing avoidable ambulatory sensitive admissions

Strategic Plan - 2015

- Work closely with HHC to increase Case Management (CM) referrals (including high risk OB members), member focused education and improved quality scores.
- Integrate physical and behavioral health Case Management services to significantly improve the outcomes of members with behavioral health diagnosis.

Strategic Plan - 2015

4. Continued focus on Compliance:

- Comply with all regulatory and HHC requirements, with a focus on changes being implemented by NYS and CMS, including new populations and benefits.
- Successfully complete New York State Department of Health and CMS audits.
- Enhance the Special Investigations Unit (SIU) function to prevent and detect potential fraud and abuse and improve the level of financial recovery in identified cases.

Strategic Plan - 2015

- Conduct internal audits; share findings and ensure recommended corrective actions plans are implemented.
- Update "MetroPlus Compliance Program Guidelines" as needed, consistent with the US Department of Health and Human Services, Office of the Inspector General, and New York State Office of the Medicaid Inspector General standards.

Strategic Plan - 2015

5. Organizational Effectiveness – Technological Excellence:

- Apply technological solutions to improve operational effectiveness of health plan.
- Develop an information system strategy to meet MetroPlus' long term growth needs.
- Continue to refine and update the business continuity plan to keep up with company growth and the ever-changing business requirements to minimize the effects of any interruption.
- Ensure compliance with use of ICD-10 code set by October 2015.

Strategic Plan - 2015

6. Organizational Effectiveness – People and Processes:

- Develop and enhance training programs, including online learning.
- Implement a Project Management approach for major initiatives.
- Develop and implement a Succession Plan.
- Identify career development opportunities.
- Continue to recruit and retain qualified candidates.
- Improve employee satisfaction based on input from Employee Surveys.

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

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

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

Attached are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

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.

I have included the MetroPlus 2015 Strategic Plan with my report to this committee. Before I conclude my report, I would like to ask if there are any questions, concerns, or suggestions for the plan.

Bert Robles, Senior Vice President/Corporate CIO
Enterprise Information Technology Services
Report to the M&PA/IT Committee to the Board

Thursday, February 12, 2015- 9:00 AM

Thank you and good morning. I'd like to update the Committee 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.

1. 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.

2. <u>Meaningful Use (MU) Update:</u>

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.

3. <u>Epic EMR Implementation Program</u>:

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.

<u>Infrastructure:</u>

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.

This completes my report today. Thank you.

Delivery System Reform Incentive Payment (DSRIP) Program

Planning + Implementation Update

M+PA/IT Board Committee Meeting
Christina Jenkins, MD
Sr AVP, Quality, Performance + Innovation
February 12, 2015

Agenda

- Review of DSRIP goals
- Recent and future DSRIP workstreams
- Overview of project implementation planning
- Overview of NYS Capital Restructuring Program
- PPS Governance

DSRIP Goals

New York State (NYS) received federal approval to implement a Delivery System Reform Incentive Payment (DSRIP) program that will provide funding for public and safety net providers to transform the NYS health care delivery system.

Goals:

(1) Transform the safety net system

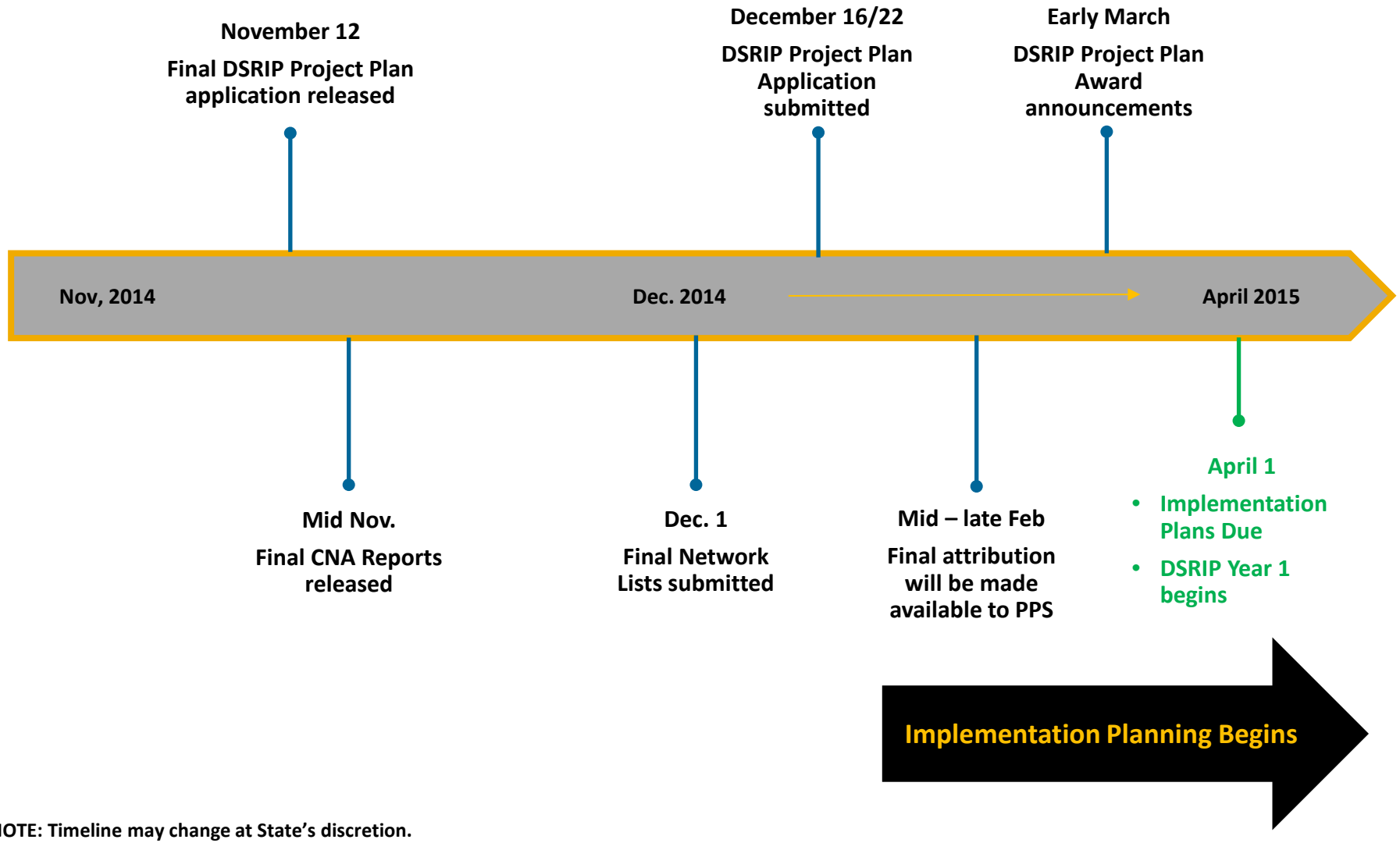
(2) Reduce avoidable hospital use by 25% and improve other health measures

(3) Ensure delivery system transformation continues beyond the waiver period through managed care payment reform

Summary of Accomplishments: 2H, 2014

- **From July through December, 2014:**
  - Finalized project selection
  - Aligned project selection across city
  - Completed Community Needs Assessment (CNA)
  - Completed initial project planning
  - Formed 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 & Project Plan Application
  - Launched Capital Application Process
  - HHC Board approved creation of Central Services Organization

DSRIP timeline (2nd half of DSRIP Year 0)



NOTE: Timeline may change at State's discretion.

Current DSRIP Workstreams

- **Project implementation planning**
  - Develop project protocols
  - Maximize standardization across our PPS hubs
  - PPS-PPS collaboration to achieve a singular approach for shared partners
  - Complete NYS-required Implementation plan by April 1, 2015
  - Develop and execute project deployment strategy
- **Capital application development, review, and prioritization**
- **Staff and operationalize CSO**
- **PPS Governance**
- **IT strategy**
- **PPS partner engagement**
  - Continued information-sharing
  - Contracting
  - Reporting and technical support
- **Communications, education, and engagement**

Implementation Planning: High-Level to Local

GOAL

For 7 of our 11 clinical projects, develop unified protocols within our PPS, and across collaborating New York City PPSs. This will include two steps:

1 **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

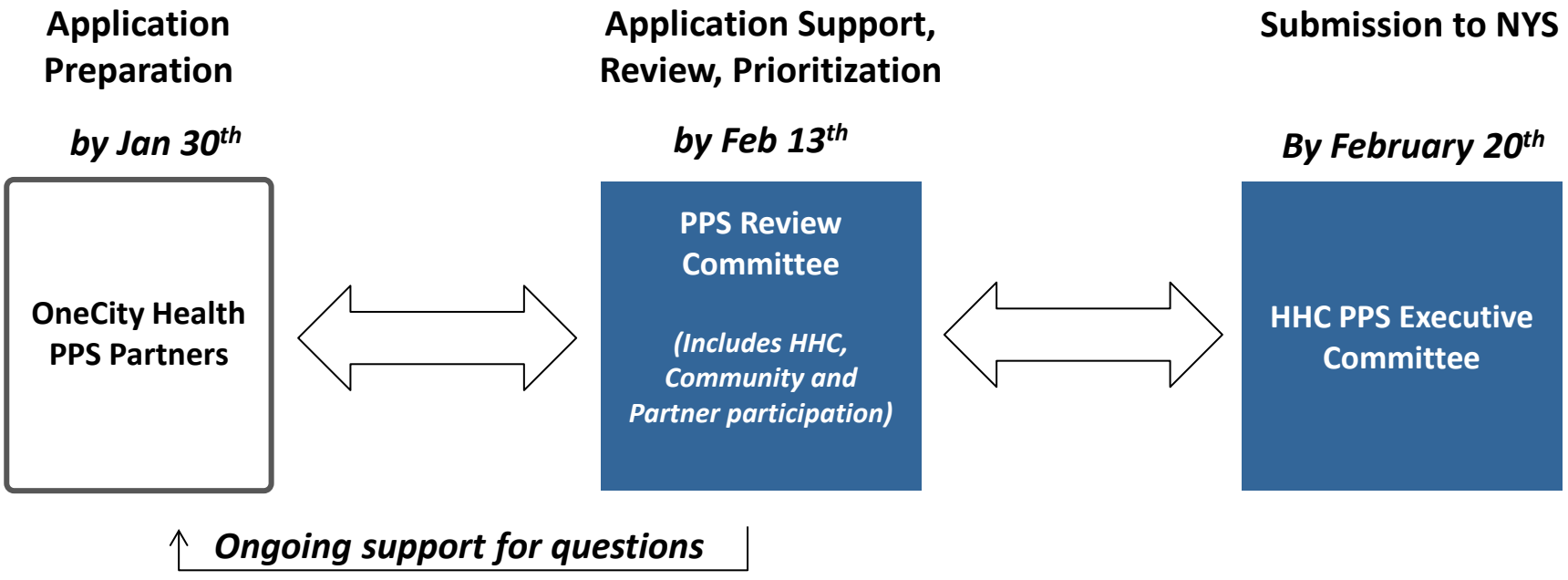
2 **Once high-level planning is well underway, launch local (hub-based) planning. During this phase, we expect to augment the "standard" templates to accommodate local variations in resources and capabilities.**

- 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

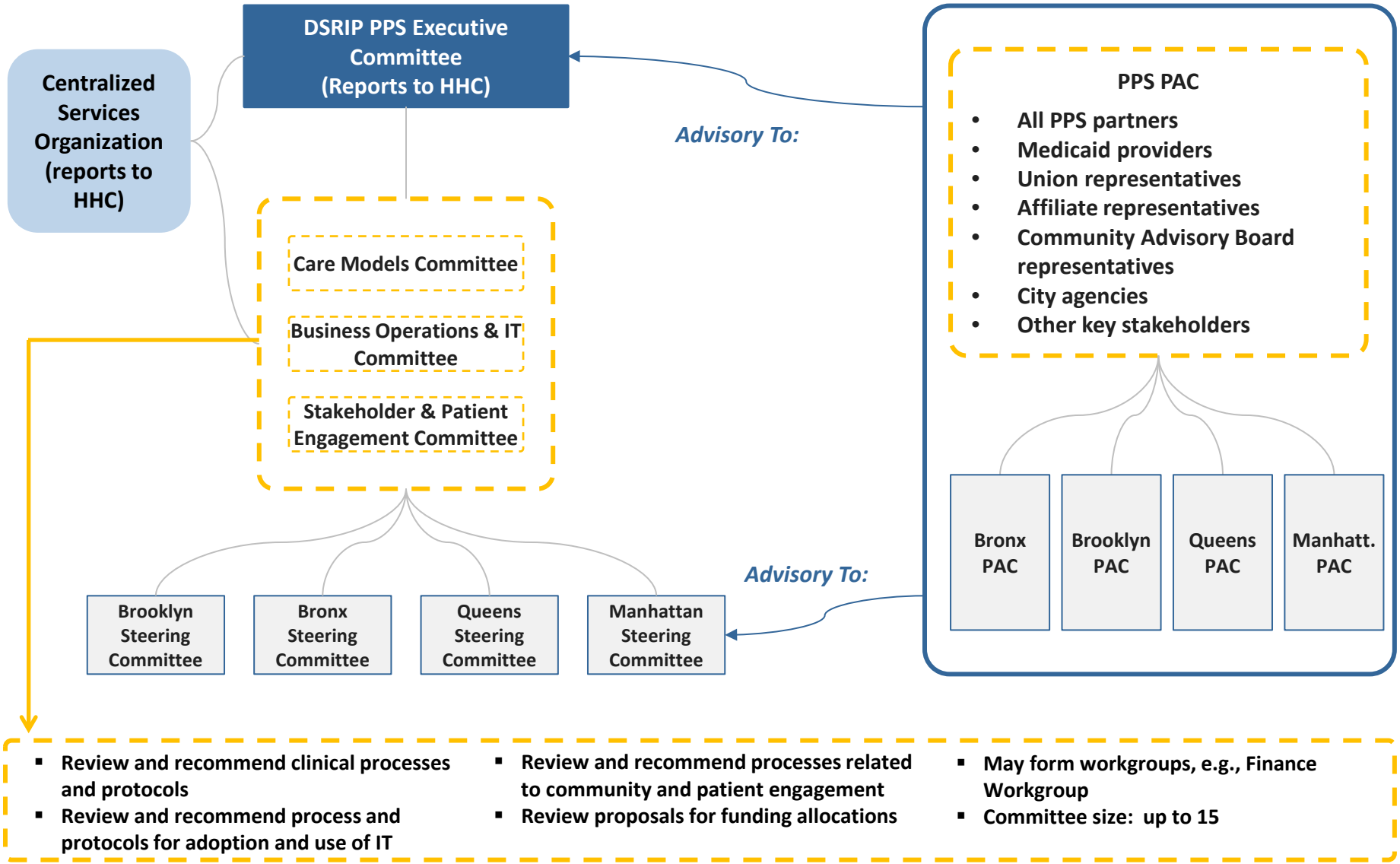
Capital Application Process

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 Governance



- Review and recommend clinical processes and protocols
- Review and recommend process and protocols for adoption and use of IT
- Review and recommend processes related to community and patient engagement
- Review proposals for funding allocations
- May form workgroups, e.g., Finance Workgroup
- Committee size: up to 15

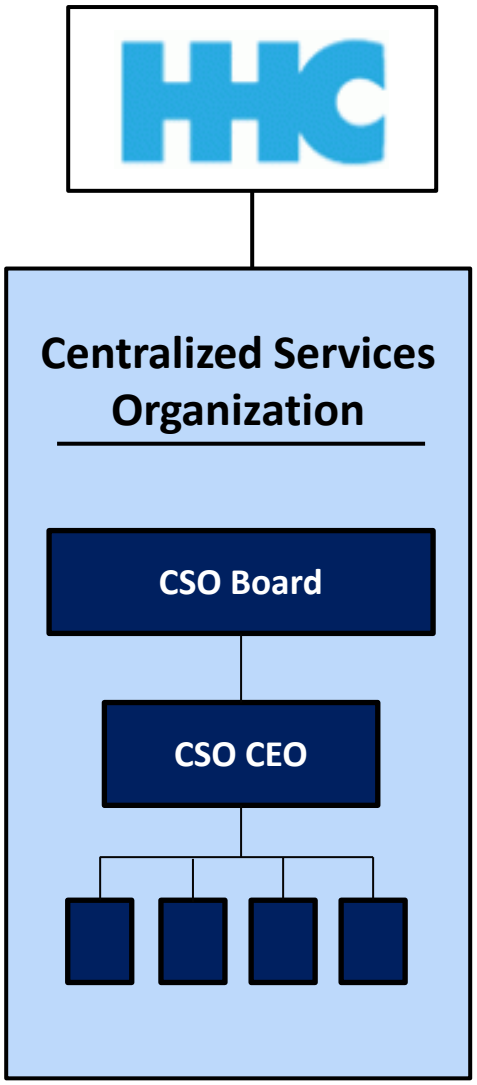
PPS Executive Committee Roles, Responsibilities, and Membership

- 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

Current PPS Executive Committee Members

Ross Wilson, HHC SVP + CMO (chair)	Christina Jenkins, HHC	John Williams, SUNY
Michael Bernstein, VNSNY	Tony Martin, HHC EVP + COO	
Claudia Calhoun, New York Immigration Coalition	Donna Colonna, CBC	
Matthew Weissman, Community Healthcare Network	William Walsh, HHC SVP, North Bronx Network	

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