AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: February 14, 2013
Time: 10:00 AM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-January 24, 2013

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

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

INFORMATION ITEM:

1. **Meaningful Use Update: Stage II** — **MR. ROBLES**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: January 24, 2013

ATTENDEES

COMMITTEE MEMBERS:

Michael A. Stocker, MD, Chairman
Josephine Bolus, RN
Vincent Calamia, MD
Amanda Parsons, MD (representing Thomas Farley, MD)

HHC CENTRAL OFFICE STAFF:

Suzanne Blundi, Deputy Counsel
Deborah Cates, Chief of Staff, Board Affairs
Christina Coiro, Director, Office of Research Management
Paul Contino, Chief Technology Officer
Mary-Ann Etiebet, Director, Ambulatory Care Transformation
Juliet Gaengan, Senior Director, Clinical Affairs
Evelyn Hernandez, Director, Media Relations
Marisa Salamone-Greason, Assistant Vice President, EITS
Caroline Jacobs, Senior Vice President, Safety and Human Development
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Irene Kaufman, Senior Assistant Vice President, Ambulatory Care Transformation
Mei Kong, Assistant Vice President, Patient Safety
Robert Kurtz, MD, Senior Clinical Advisor to Chief Medical Officer
Patricia Lockhart, Secretary to the Corporation
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
Kathleen McGrath, Senior Director, Communications & Marketing
Andreea Mera, Director, Office of Healthcare Improvement
Bob Moon, Senior Director, Office of Behavioral Health
John Morley, MD, Deputy Chief Medical Officer
Bert Robles, Senior Vice President, Chief Information Officer
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
David Stevens, MD, Senior Director, Office of Healthcare Improvement
Steven Van Schultz, Director, IT Audits

FACILITY STAFF:

Ernest Baptiste, Executive Director, King County Hospital Center
Van H. Dunn, MD, Medical Director, MetroPlus Health Plan, Inc.
Ghassan Jamaleddine, MD, Medical Director, Kings County Hospital Center
Terry Mancher, Chief Nursing Officer, Coney Island Hospital
Denise Soares, Executive Director, Harlem Hospital Center
Arthur Wagner, Senior Vice President, Southern Brooklyn/SI Network

OTHERS PRESENT:

Mindi Bieber, Director, Professional Liability Claims, Sedgwick Claims Management
Moira Dolan, Senior Assistant Director, DC 37, Research & Negotiations Department
Melissa Dubowski, Analyst, Office of Management and Budget
Scott Hill, Account Executive, QuadraMed
Megan Meagher, Analyst, Office of Management and Budget
Tamara Robinson, CIR/SEIU
Susan White, Team Lead, Professional Liability Claims, Sedgwick Claims Management

**MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, January 24, 2013**

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 10:00 A.M. The minutes of the December 13, 2012 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT:

The Chief Medical Officer's report was read into the record by John Morley, MD, Deputy Chief Medical Officer. The following initiatives were reported:

1. Super Storm Sandy

HHC is currently involved in many activities to debrief after the storm. In addition to developing internal recommendations, we are active in debriefing at City Hall and also testifying at a City Council hearing today on the same topic. This hearing has precluded Mr. Aviles and Dr. Wilson from attending today's Committee meeting.

2. Improving Access to Primary Care

A contract is being completed with the successful outside vendor to improve access to primary care services at HHC. This is a vital project to increase capacity and improve access; both essential to manage in an increasingly managed care or ACO environment. The Committee will receive further reports as the work progresses.

3. Centralized Credentialing System

The Division of Information Technology will be making a presentation to the Contract Review Committee (CRC) for an HHC Centralized Credentialing System on February 11th. After the field was surveyed and products demonstrated it is clear that there are many products far superior to the vendor that closed in May of last year. The committee that viewed the demonstration has come out with a clear leader and as it happens that this vendor is part of a GPO in which HHC participates. Cost will be approximately $1 M for centralized credentialing, privileging, application and OPPE/FPPE.

4. Post Sandy Stress Management

The Office of Behavioral Health continues to organize post Sandy Stress Management and Support Groups. These groups have been offered to all facilities and central office staff and are run by licensed mental health professionals trained in crisis debriefing and stress management. The groups will continue to run as requests are received. Primary focus is for staff returning to facilities after being deployed or relocated.

5. NYS Hospital Medical Home Demonstration Award

The New York State Department of Health (NYS DOH) has approved the work-plans submitted from all 11 HHC hospitals for the NYS Hospital Medical Home Demonstration Award. This two year award provides HHC with $38 million in the first year to support enterprise-wide initiatives and targets for PCMH transformation and primary care resident continuity; behavioral health and primary care integration; primary and specialty care access; and hospital quality improvement and safety. Initial award disbursements have been received by HHC and will support priority non-recurrent investments in training, systems and infrastructure needed to meet demonstration objectives. There is a possibility for funding for a second year.

6. Flu: Public Health Emergency declaration

HHC has seen a large increase in emergency room visits and admissions for adults and children with influenza-like illness. In addition there have been an increased number of cases amongst residents at Sea View Hospital Rehabilitation Center & Home and Coler-Goldwater Specialty Hospital and Nursing Facility. There will be a presentation later in the meeting which will address this issue, but we continue to be concerned by a low employee vaccination rate. Preparations are being made to move in the same direction as many NYC hospitals, which is to require employees who have refused vaccination, to wear a mask for the duration of the flu season.

Amanda Parsons, MD, requested that an update on HHC's Health Home initiative be provided at the February 2013 Committee meeting.

CHIEF INFORMATION OFFICER REPORT

Bert Robles, Chief Information Officer provided the Committee with updates on the following initiatives:

1. ICIS Electronic Medical Record (EMR) Program Update

HHC signed a contract with EPIC for a new Electronic Medical Record system. Getting this program planned, designed, built, tested and deployed over the course of the next five (5) years will consume every Enterprise IT Services (EITS) resource going forward. However, I am very confident that every staff member is up to this critical challenge.

Activities will now transition from the selection process to intensive implementation planning. As we move forward, one of the critical success factors will be the involvement of our clinicians and staff across all HHC facilities. The program team is working to identify the specific resource skill and time commitment that will be needed to perform the preparation activities and design of the ICIS application. Drafted governance and operating procedures have been drafted to be shared and discussed in detail with HHC leadership. Within the next few weeks we will be contacting each facility for representatives. This will be an application for our clinicians that is designed by our clinicians. The continued support by the Board of this important project over the coming months of planning, designing, building, testing and training is extremely important and will ensure our successful implementation of a robust clinical application that will support our patients and clinicians.

2. Kings County Hospital Failover Test Results

Earlier this month, EITS concluded another successful disaster recovery test of our Electronic Medical Records Systems. This routine test, performed on the Kings County Hospital Center database, is part of on-going disaster preparedness activities throughout the Corporation. New York City's recent experiences with natural disasters and utility disruptions underscore the importance of on-going readiness through drills such as this one. Mr. Robles congratulated the teams at Kings County and Central Office for their continued focus on these important activities.

3. Care Coordination Program Update

In conjunction with Mr. Robles, Irene Kaufman, Senior Assistant Vice President, Office of Ambulatory Care Transformation and Paul Contino, Chief Technology Officer presented on this program. Highlights of the presentation included the following:

To support the needs of the New York State (NYS) Health Homes program and the larger Patient Centered Medical Home (PCMH), HHC has acquired a Care Plan Management System (CPMS) from Microsoft. This web based platform will facilitate the creation and documentation of patient care plans and greatly improve the information exchange and access for all care team providers, including both HHC and non-HHC providers.

CPMS will provide a vehicle for capturing patients care needs and self-management goals, as well as the care teams activities and interventions supporting the patient's ability to meet those goals. In addition the system will support patient tracking and reporting, consent management and trigger automatic alerts and flags to notify providers regarding key events. CPMS provides critical linkage of information that is often not well documented in the medical record and goes beyond the typical care management of a clinical provider, encompassing non-clinical aspects of care such as social services and housing. This will provide the care team with a much more integrated view of the care coordination activities for the patient.

To date we have successfully installed the software components of the system and setup a number of the key interfaces needed to send patient demographics and select clinical information (allergies, meds, labs) to the CPMS database. The first phase of the project focuses on the setup and deployment of the administrative components needed to manage patient enrollment, care team assignment and reporting as well as the provider portal that will be used by the care team members to access and manage a patient's care plan. The second phase will expand upon the care plan system and deploy the patient portal (personal health record).

The care plan templates under development and expected to have a working version of the CPMS demonstrated to us by the end of November was delayed due to recent events of Hurricane Sandy. The new timeline is as follows: Phase 1 (provider portal) was anticipated to go-live Feb 2013 is now moved to March 2013; Phase 2 (patient portal) will remain as scheduled in May 2013.

Ms. Kaufman and Mr. Contino provided the Committee with slides of CPMS screen shots for the patient roster management and all levels of care plan modules.

Mr. Robles also informed the Committee that recently Microsoft has entered into a joint venture with GE to form a new company (Caradigm) which now owns and supports the CPMS product. Microsoft and GE are each 50% owners of the new company. However, this development should have little or no impact on our program.

Dr. Stocker inquired about the connectivity with various RHIOS (besides Interborough, which we are connected with). Paul Contino answered that New York Health Collaborative is working towards consolidating the infrastructure/integrating the RHIOS and confirmed that the Corporation is technically prepared to connect to the RHIOS. The question arose as to whether there was a time limit on the Health Home. Irene Kaufman and Bert Robles confirmed the immediate requirement and the current development of methodologies to meet such requirements.

Dr. Parons added that there has been policy and technical barriers in consolidating the RHIOS. The plan is that in April 2013 the RHIOS will be connected. Long term plan is that the City RHIOS will be connected to the State, etc. The State has not regulated RHIOs connectivity.

Mr. Robles noted that the greatest barrier has been the consent issue as the NYS consent form is very restrictive. Ms. Kaufman noted that the patient enrollment process includes consent to sharing information as part of participating in the program.

Dr. Stocker inquired as to whether the current consent form indicates an option to share information with providers from within and outside the system. Ms. Kaufman responded that the Health Home Consent includes all the providers within HHC, the patient selects the other providers who can receive information. Dr. Stocker inquired as to why HHC is being so restrictive? Ms. Kaufman responded that restriction comes from NYS, not from HHC. Mr. Robles stated HHC wrote a letter to NYS expressing concerns about the consent restrictions and asking for a review of the form. Dr. Stocker asked for a copy of the letter and in the meantime he would share the Montefiore consent form.

Mrs. Josephine Bolus inquired as to whether HHC is protected if there is a case of a patients' information being hacked. Mr. Contino advised that the Corporation is protected because it does not own the information: the consent states that the patient owns the information. HHC is only pushing such information to their personal record. Dr. Stocker further inquired as to whether the patient's information can be pulled up in an EMR if needed in a hospital and as to whether the nurses in the Health Home System can access the patient information. Mr. Contino responded affirmatively to both. It is a web based system, therefore allowing access from any location. Dr. Stocker inquired as to whether there is a requirement for formal medication reconciliation. Ms. Kaufman advised there is no requirement for a formal medical reconciliation, but we are moving in that direction.

METROPLUS HEALTH PLAN, INC.

Dr. Van Dunn, Medical Director, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Dunn informed the Committee that the total plan enrollment as of December 31, 2012 was 438,543. Breakdown of plan enrollment by line of business is as follows:

Medicaid	372,942
Child Health Plus	14,486
Family Health Plus	36,110
MetroPlus Gold	3,099
Partnership in Care (HIV/SNP)	5,712
Medicare	6,194

This month, MetroPlus lost 1,964 members. This loss is due to a catch-up of retroactive disenrollments that the State had delayed processing due to Hurricane Sandy. Preliminary numbers for the month of January show a recovery growth in membership of approximately 4,000 members. MetroPlus experienced a modest gain in Medicare, gaining 56 enrollees.

Dr. Dunn provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

Dr. Dunn informed the Committee that MetroPlus' membership losses to HealthFirst and Fidelis continue to decline. This month shows that the combined losses are down to 1,200 from 2,100 per month this summer.

MetroPlus' recovery post Hurricane Sandy is going very well. Their main offices at 160 Water Street are inaccessible due to flooding and damage, and 160 Water Street building operations are now estimating that MetroPlus will be unable to return to the building until at least April 2013. Currently, almost all of MetroPlus operations are located at our offices at 40 Wall Street and 33 Maiden Lane. Our Claims and HIV SNP staff continue to function at our SunGard Long Island City location. These off-site team members are fully productive and communications with our Manhattan locations are seamless.

This month, MetroPlus underwent a Centers for Medicaid and Medicare (CMS) financial audit. This audit was also delayed because of Hurricane Sandy but despite their displacement, they were able to successfully

complete the audit. The preliminary results from this audit were extremely positive. MetroPlus was told of minor observations for issues out of their control, such as two members that had not signed for their prescriptions upon pickup in the retail pharmacy setting. Overall, CMS remarked that MetroPlus had excellent performance on this audit.

MetroPlus continues to prepare to submit their bids for the NYS Health Benefit Exchange. The NYS Health Benefit Exchange will go live in the Fall of 2013. Insurers seeking to offer Qualified Health Plans (QHP) will be asked to submit plan designs in March 2013. QHPs are classified into 4 types of product levels, Platinum, Gold, Silver, and Bronze; with progressively increased copayments and deductibles. Within the Silver plan there are three additional levels of coverage based on a member's income as compared to the federal poverty level. Given these requirements, MetroPlus must offer a minimum of 8 products in the NYS Health Benefit Exchange, which will also include a Catastrophic Plan. Because of the changes as part of the Exchange, Family Health Plus will probably be discontinued when the Exchange products go live. Family Health Plus represents about 8% of MetroPlus' current membership. MetroPlus is striving to offer products that these members can afford and will enroll in, to minimize a loss in membership. MetroPlus' target population for the Exchange will be the Silver Plan with the four different levels based on income for individuals and Small Business Health Options (SHOPs). At the core of these product offerings will be their HHC facilities and the existing MetroPlus networks.

The State Department of Health has recently implemented more stringent processes to block enrollment of individuals with comprehensive third party health insurance (TPHI) into Medicaid managed care. The Department is undertaking a process to disenroll individuals that have TPHI and will provide plans with a file of identified enrollees 60 days prior to disenrollment. Plans may provide evidence of non-coverage to DOH on any identified members within the 60 day window for removal from the disenrollment file. MetroPlus has received their list of members and approximately 6,200 of our members are shown to carry third party health insurance. MetroPlus has begun a full scale outreach plan to gather evidence of non-coverage in an effort to retain this segment of our Medicaid membership.

Effective January 1, 2013, the Affordable Care Act requires that Medicaid payments to primary care physicians must be at least the level of the 2013 Medicare rate. CMS finalized regulations implementing the payment requirements in November, and DOH has begun to develop a methodology for calculating the necessary payment increases for both fee-for-service and managed care. Plans are required to ensure payments to qualifying providers are at the minimum required levels, though it remains unclear how sub-capitation payment arrangements with providers will be evaluated. Providers are required to attest to their eligibility for the payment enhancements. DOH must submit a calculation methodology to CMS by March 31, 2013, and CMS must review the methodology within 90 days. After approval by CMS, retroactive adjustments will be made to provider payments back to the January 1 effective date. MetroPlus in the process of updating our fee schedules to comply with this change.

ACTION ITEM:

1. Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to execute a Sole Source contract with Sedgwick Claims Management (Sedgwick) to provide specialized claims and risk management services to the Corporation in connection with medical malpractice claims, and to manage subcontracts for risk reduction education, and insurance consulting and management for a term of four years with an option to renew for one additional two year term, solely exercisable by the Corporation, for an amount not to exceed $34,434,496.00.

Presenting to the Committee was Salvatore Russo, General Counsel and Suzanne Blundi, Deputy Counsel. The accompanying resolution requests authorization for a four year sole source contract, with the option of a two year renewal, with Sedgwick Claims Management (Sedgwick) to provide claims and risk management services in connection with medical malpractice claims for HHC.

Efforts to successfully defend malpractice cases or to settle cases early in litigation at an advantageous cost are enhanced by active claims and risk management. Prior to FY 2002, these efforts had been localized at the Corporation's facilities and varied in their effectiveness. Defense efforts were sometimes hampered by the lack of efficient systems to gather evidence, analyze claims and institute risk management initiatives. Beginning in FY 2002, the Corporation agreed to reimburse the City for medical malpractice indemnity costs up to an annual maximum "cap".

Also beginning in 2002, the Corporation instituted a comprehensive claims and risk management program, including the provision of claims and risk management by an outside vendor. As a result of these combined efforts, the Corporation's payment to the City under the "cap" have been reduced by a total of approximately $144 million for FY 2008, FY, 2009, FY 2010 and FY2011.

Sedgwick (formerly Caronia) was first retained as part of this initiative in February of 2002 after an RFP. Since that time they have provided claims and risk management services to the Corporation. Sedgwick's efforts have formed the basis for the success of the medical malpractice reduction initiative, including a successful Early Settlement program, improving the defense of medical malpractice cases and establishing an industry best practice system for the captive insurance program.

Each year, the Corporation is served with approximately 600 new claims alleging medical malpractice and hospital negligence. This number represents a drop of 50 claims per year since the initiative was started. At present, approximately 1,750 matters are pending with approximately 280 concluded each year with monetary payment.

This sole source contract is proposed in order to continue Sedgwick's work in maintaining a claims and risk management infrastructure under this contract. Sedgwick will continue to provide the claims investigation, risk management and claims services that have formed the basis for the Corporation's successful medical malpractice reduction initiative.

Mr. Russo and Ms. Blundi provided the Committee with the program description, objectives, results and accomplishments as follows:

Sedgwick provides early investigations and analysis of the Corporation's medical malpractice exposure and aggressive disposition strategies of liability cases, Sedgwick is responsible for handling all professional liability claims for HHC's facilities as well as claims management services for HHC's captive, HHCIC, with primary responsibility for managing liability claims for individual obstetricians, gynecologists and neurosurgeons and apprising the excess carrier of exposures. A total of 34 employees service the needs of HHC on this program. Since 2002, Sedgwick has managed over 7,500 cases for HHC, commencing with all claims filed on or after July 1, 2001.

The primary program objectives are: to commence early investigation of cases, including record review and interviews with key practitioners; to work collaboratively with facilities to identify risk management issues; to pursue early claim resolution of liability cases; to maintain a comprehensive claims database; and to conduct NY State and databank reporting.

Claims Investigation is prioritized according to injury types and levels. Sedgwick nurse investigators are aggressive in securing and completing record reviews prior to the 50-h hearings. Interviews with key

practitioners are conducted on all cases. To date, a total of 14,266 investigative reports have been completed by Sedgwick nurse consultants.

The claims staff has worked collaboratively with HHC to identify claims and suits for early resolution and to develop an action plan to resolve the case in an expeditious manner. Over the course of the program hundreds of cases have been identified for early settlement. Over the past year alone, the claims specialists identified 150 potential early settlement matters.

Sedgwick maintains a comprehensive claims database with extensive claim notes detailing the progression of the case and litigation. Coding is a key element of our claims system that enables risk data to be tracked. From this data, HHC develops patient care improvement initiatives.

Sedgwick complies with all reporting requirements required by the National Practitioner Data Bank and NY State Department of Health. To date, over 5,000 State Reports were submitted and 119 Data Bank reports were filed.

Sedgwick has developed customizable risk management reports and provided training to facility personnel on the iVOS Reporter tool. These reports enable the facilities to identify losses specific to injury types, departments, cause of loss, and accident locations.

Accomplishments include: streamlined the process at HHC facilities for sequestering medical records and fetal monitoring strips; instituted an online repository for clients to access defense counsel and Sedgwick reports; our claims specialists have prepared 4,128 reserve reports since inception of the program; fulfilled reporting obligations pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA); careful compliance with reporting requirements helps HHC avoid penalties of up to $1000 per claim per day; and our Nurse Consultant Supervisors have conducted facility visits with risk management at all 11 institutions over the past year to ensure direct client communication and satisfaction.

Vincent Calamia, MD inquired as to how do we compare to other systems as far as malpractice liability claims. Ms. Blundi advised that HHC is doing very well. NYC Comptroller's Office has declared that HHC's model should be followed by the other City agencies. Dr. Calamia then asked whether HHC physicians are covered. Ms. Blundi responded that HHC clinicians are fully indemnified. The Committee inquired as to what happens if a nurse gets sued, which takes precedence, their own insurance or HHC. The Committee was informed that nurses hardly ever get personally sued and they rarely have their own insurance, therefore it is HHC that would handle the claim.

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

INFORMATION ITEM:

1. Flu Update at HHC

Presenting to the Committee was John Morley, MD, Deputy Chief Medical Officer. The presentation began with a map that demonstrated the distribution of influenza as created by the Centers for Disease and Control (CDC) for the week ending January 12, 2013. This slide basically shows that the influenza is widespread throughout the United Sates, but does not measure the severity of the influenza activity. Other data shown by the CDC included: influenza positive tests reported to the CDC; pneumonia and influenza mortality; laboratory-confirmed influenza hospitalizations; and percentage of visits for influenza-like illness (ILI) reported by the U.S. Outpatient ILI Surveillance Network.

Dr. Morley then provided the Committee with a copy of the executive order issued on January 12, 2013 by Governor Cuomo which declared a State public health emergency in response to severe flu season. The executive order primarily permits pharmacists to expand their vaccination practice to administer flu vaccinations to patients between the age of six months and 18 years of age. Additionally, Governor Cuomo's announcements indicated that as of January 5, 2013, the New York State Department of Health (NYSDOH) received reports of 2,884 patients hospitalized with laboratory-confirmed influenza, a significant increase compared to 1,169 total hospitalized in 2011. HHC flu visits and admissions per day for both adults and pediatrics were provided to the Committee for the period of January 9 through January 22, 2013.

Dr. Morley concluded with highlighting the following current steps for HHC:

The season's flu vaccination rates to-date are inadequate (37% for employees) thus HHC is further promoting vaccination; we are working on a policy that vaccination become a condition of employment for new hires; and collaborating with the NYSDOH, Greater New York Hospital Association, and HANYS on instituting a policy in which if a health care worker does not get vaccinated they will be required to wear a mask during the entire flu season while delivering patient care; promoting use of Tamiflu and testing according to CDC; promoting vaccination, hand hygiene, cover your cough and stay home if you are sick; and roviding overflow capacity for emergency rooms.

There being no further business the meeting adjourned at 12:32 P.M.

Bert Robles
Senior Vice President, Information Technology Services
Report to the M&PA/IT Committee to the Board
Thursday, February 14, 2013 – 10:00AM

Thank you and good morning. I would like to provide the Committee with the following update:

1. **Meaningful Use (MU) Stage 2 :**

This morning we have a Meaningful Use presentation for the committee but I also wanted to briefly update the members as to the Corporation's status to meet Meaningful Use Stage II.

The Corporation continues efforts to meet requirements under the American Recovery and Reinvestment Acts (ARRA) program for Meaningful use of Electronic Health Records. This national program aims to increase the prevalence of electronic health record use across all providers of care including hospitals and community practitioners with the aim of forming a more connected healthcare system that is necessary to coordinate care, improve efficiency, decrease cost, and improve quality. This multi-year program has several Stages which will evolve over the coming years. Each Stage contains new requirements and providers are rewarded with incentive funds for achieving and sustaining each Stage.

In the fall of 2012, all eleven HHC facilities attested to achieving Stage 1 Meaningful Use. As a result, HHC received $17million of incentive funding

under the Medicare portion of the Program and another $43.5 Million in Medicaid incentive dollars. In Stage 1 of the program, Hospitals need to meet minimum thresholds with fourteen core program measures as well as five menu measures. This stage continues for another year. HHC will receive additional incentives in 2013, provided Hospitals continue to meet these minimum thresholds. HHC is currently on track to do so and we continue to monitor performance across the system. To monitor for ongoing compliance all eleven hospitals run monthly reports on these performance measures.

Even as HHC remains focus on sustaining Stage 1, the Corporation is preparing for Stage 2 of the program. Stage 2 of the program includes both new requirements not previously part of Stage 1, as well as increased achievement thresholds for existing requirements. Among the changes are the requirements for Bar Coding of medications as well as the ability for a patient to download an admission summary within 36 hours of hospital discharge. In addition, several of the measures, which were optional in Stage 1, are now required in stage 2, including transition of data to immunization registries, medication reconciliation, and patient specific education resources. In addition to meeting the Meaningful Use Criteria described above, each hospital will need to electronically transmit sixteen Quality measures to CMS.

As was the case in preparing for Meaningful Use Stage 1, Stage 2 will require several major software upgrades. These include moving from the current QuadraMed software version of 5.2, first to version 5.4 and ultimately to version 6.0. QuadraMed has advised HHC that the 6.0 version

will not be generally available until the third quarter of calendar year 2013. However, it is anticipated that several HHC facilities will participate in the Beta release of this version which will give HHC an opportunity to test the system and test the features and functions in the release. All facilities are expected to be on version 5.4 by June 30, 2013. In addition to these software upgrades, there is also a database upgrade for the Cache database as well as updates to the MediSpan drug database.

As was the case for attestation in Stage 1, the first year of Stage 2 is allows for a 90 day compliance period as opposed to 365 days in subsequent years. However, unlike stage 1, which allowed hospitals to choose any 90 day period, Stage 2 requires the period to coincide with a quarter within the Federal Fiscal year. HHC plans to have all software upgrades completed by the fall of 2013, thus permitting hospitals to attest in one of the three remaining quarters of the fiscal year: January – March 2014; April – June 2014; or July – September 2014 (last chance).

This completes my report to the Committee today. Thank you.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
February 14th, 2013

Total plan enrollment as of January 31st, 2013 was 443,173. Breakdown of plan enrollment by line of business is as follows:

Medicaid	377,914
Child Health Plus	13,466
Family Health Plus	36,467
MetroPlus Gold	3,287
Partnership in Care (HIV/SNP)	5,679
Medicare	6,354
MLTC	6

From December to January, we gained 4,630 members. We experienced a positive gain in Medicare, gaining 160 enrollees.

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.

Our membership losses to Health First and Fidelis are holding steady at 1,200 per month. We continue to reevaluate our marketing and retention efforts to address these losses. The losses due to the dental plan change have tapered off, and we are working with Healthplex to continually improve our dental network's satisfaction.

We were informed this month that 160 Water Street will be open and available for occupancy on February 15th, 2013. Our move back to 160 Water Street is dependent on air quality safety, as well as full availability of phone and data services. We are working on our plan for relocating all areas and anticipate having all operations back at 160 Water Street by mid-March 2013.

This month, we completed an analysis of our Medicare disenrollments and found that the majority of our losses were because members voluntarily disenrolled to join another plan. The largest segment of the members surveyed left our Platinum product to join Healthfirst Medicare.

Enrollment for our new Managed Long Term Care product began on January 1st, 2013. We currently have 6 members and are expecting 22 new members in February, including 13 new auto assignments.

MetroPlus is in the process of preparing to submit an application for the Fully Integrated Duals Advantage (FIDA) program. FIDA is a three-year demonstration project designed to test new service delivery and capitated payment models for beneficiaries dually eligible for Medicaid and Medicare. These beneficiaries must require more than 120 days of long term support and services. The demonstration project will be effective in January 2014 and will service eight New York counties, including Bronx, Kings, New York, Queens, Nassau, Suffolk, Richmond and

Westchester. The total number of beneficiaries eligible for the demonstration is estimated at 123,000. Beneficiaries currently enrolled in the MetroPlus MLTC program will be passively enrolled in the FIDA program, with an option to opt-out. All Medicare Advantage plans will transition to a product line to provide FIDA. Otherwise, plans that do not transition to FIDA will only serve duals that opt-out or dis-enroll from FIDA. The initial application is due to CMS February 15th, 2013.

On January 31, 2013 the New York Health Benefit Exchange issued its invitation to health insurers and dental plans to participate in the New York Health Benefit Exchange. The letter of interest is due on February 15th, 2013, and the submission of a participation form is required by April 5th, 2013. NYS Health Benefit Exchange will go live in October 2013. Qualified Health Plans (QHPs) are classified into 4 types of product levels, Platinum, Gold, Silver, and Bronze; with progressively increased copayments and deductibles. Within each plan there will be an additional pediatric option and within the Silver plan there are three additional levels of coverage based on a member's income as compared to the federal poverty level. Given these requirements, MetroPlus must offer a minimum of 16 products in the NYS Health Benefit Exchange, which will also include a Catastrophic Plan.

Governor Cuomo released his Executive Budget on Tuesday January 22nd, 2013. The Executive Budget proposes to revise existing Medicaid categories and convert eligibility levels to a Modified Adjusted Gross Income (MAGI) equivalent standard. The Executive's proposal establishes a new adult category for individuals ages 19 to 64 with incomes below 133 percent of the Federal Poverty Level (FPL) and provides that these beneficiaries receive a Benchmark benefit package. There will also be unique eligibility levels for pregnant women, parents, infants and children The Executive Budget also defines the Medicaid eligibility categories that will not be subject to MAGI financial methodologies and adds a new mandatory eligibility category for former foster care children, up to age 26 years old, who were receiving Medicaid when they aged out of foster care. The Executive Budget establishes 12 month continuous eligibility for individuals whose Medicaid eligibility is based on MAGI methodologies, except for individuals whose eligibility changes due to citizenship, residency or failure to provide a valid social security number.

Other changes in the Executive Budget include:

- Medicaid global cap (3.9%) remains in place and the 2% across-the-board payment cut, which was scheduled to expire at the end of this fiscal year, is extended through March of 2015;
- A repeal of "prescriber prevails" authority for atypical antipsychotics in Medicaid managed care and in the entire Medicaid fee-for-service (FFS) pharmacy program;
- Institutes a new $20 million quality incentive program for the Managed Long Term Care program;
- Eliminates statutory impediments to enrolling excluded FFS populations into Medicaid managed care;
- Amends the autism mandate to replace the $45,000 annual benefit cap with 680 hours of treatment per policy or calendar year;

- Enacts numerous provisions that will enable New York to align and conform with the federal Affordable Care Act (ACA) and move forward with the New York Health Exchange including:
    - Beginning a phase out of the Family Health Plus (FHP) and FHP buy-in programs;
    - Eliminating the standardized individual direct pay products, effective October 2013, and establishing a new individual market product outside of the Exchange that must conform to Exchange requirements;
    - Eliminating the Healthy New York program, effective December 31, 2013.

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

January-2013

		Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Total Members	Prior Month	435,745	436,882	438,869	437,987	437,475	438,952	439,979
	New Member	17,049	19,115	15,924	14,282	19,046	10,537	12,774
	Voluntary Disenroll	2,593	3,471	3,072	2,578	3,262	2,132	2,492
	Involuntary Disenroll	13,319	13,657	13,734	12,216	14,307	7,378	7,088
	Adjusted	7	4	7	51	-1,539	1,433	0
	Net Change	1,137	1,987	-882	-512	1,477	1,027	3,194
	Current Month	436,882	438,869	437,987	437,475	438,952	439,979	443,173
Medicaid	Prior Month	367,807	369,015	371,622	371,453	371,413	373,606	374,361
	New Member	14,044	16,194	13,322	11,850	16,304	8,722	10,298
	Voluntary Disenroll	2,174	2,904	2,599	2,192	2,829	1,822	2,037
	Involuntary Disenroll	10,662	10,683	10,892	9,698	11,282	6,145	4,708
	Adjusted	0	1	5	41	-1,213	1,419	0
	Net Change	1,208	2,607	-169	-40	2,193	755	3,553
	Current Month	369,015	371,622	371,453	371,413	373,606	374,361	377,914
Child Health Plus	Prior Month	16,339	16,095	15,693	15,371	15,122	14,670	14,483
	New Member	451	398	437	468	454	216	331
	Voluntary Disenroll	38	53	33	35	39	21	39
	Involuntary Disenroll	657	747	726	682	867	382	1,309
	Adjusted	0	0	0	0	-1	-3	0
	Net Change	-244	-402	-322	-249	-452	-187	-1,017
	Current Month	16,095	15,693	15,371	15,122	14,670	14,483	13,466
Family Health Plus	Prior Month	36,826	36,888	36,667	36,304	36,024	35,675	36,114
	New Member	2,075	2,173	1,819	1,603	1,917	1,279	1,489
	Voluntary Disenroll	220	366	243	215	260	151	205
	Involuntary Disenroll	1,793	2,028	1,939	1,668	2,006	689	931
	Adjusted	0	0	0	2	-318	4	0
	Net Change	62	-221	-363	-280	-349	439	353
	Current Month	36,888	36,667	36,304	36,024	35,675	36,114	36,467

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

January-2013

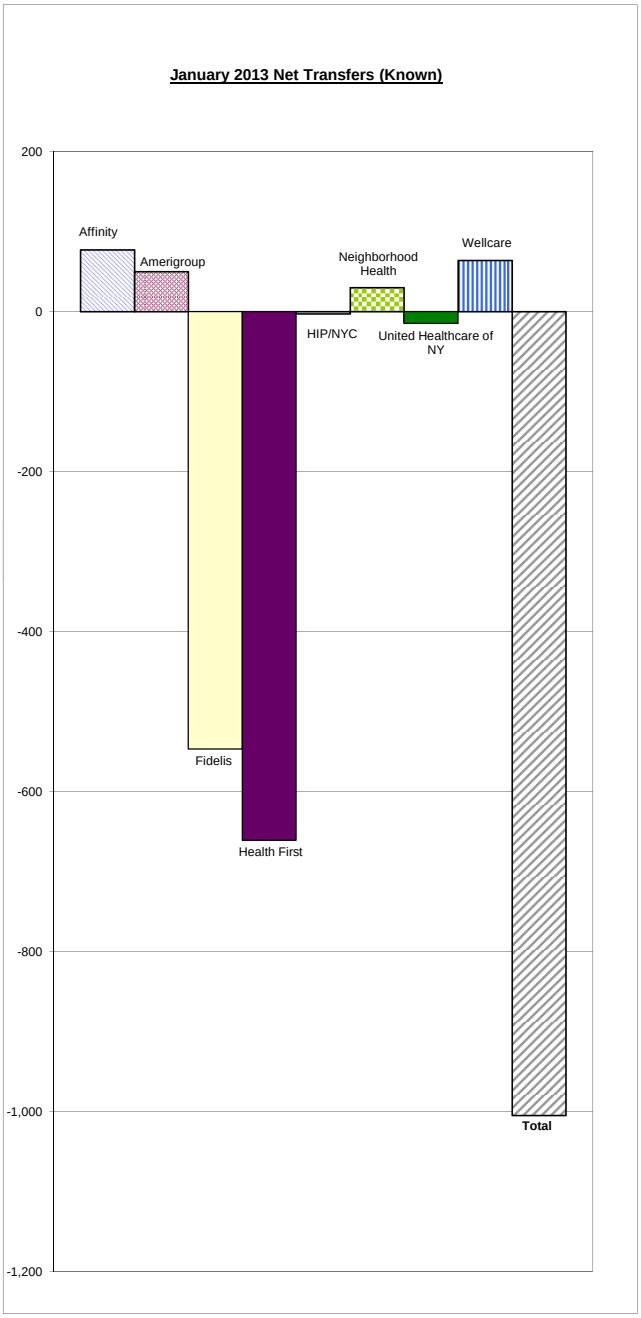
		Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
HHC	Prior Month	3,152	3,191	3,133	3,135	3,138	3,117	3,121
	New Member	73	16	25	24	7	16	186
	Voluntary Disenroll	0	0	2	0	0	0	0
	Involuntary Disenroll	34	74	21	21	28	12	20
	Adjusted	7	4	3	9	8	20	0
	Net Change	39	-58	2	3	-21	4	166
	Current Month	3,191	3,133	3,135	3,138	3,117	3,121	3,287
SNP	Prior Month	5,818	5,801	5,788	5,771	5,752	5,746	5,713
	New Member	134	110	107	94	103	74	64
	Voluntary Disenroll	50	42	43	33	33	27	32
	Involuntary Disenroll	101	81	81	80	76	80	66
	Adjusted	0	0	-1	-1	-15	1	0
	Net Change	-17	-13	-17	-19	-6	-33	-34
	Current Month	5,801	5,788	5,771	5,752	5,746	5,713	5,679
Medicare	Prior Month	5,803	5,892	5,966	5,953	6,026	6,138	6,187
	New Member	272	224	214	243	261	230	400
	Voluntary Disenroll	111	106	152	103	101	111	179
	Involuntary Disenroll	72	44	75	67	48	70	54
	Adjusted	0	-1	0	0	0	-8	0
	Net Change	89	74	-13	73	112	49	167
	Current Month	5,892	5,966	5,953	6,026	6,138	6,187	6,354
Managed Long Term Care	Prior Month	0	0	0	0	0	0	0
	New Member	0	0	0	0	0	0	6
	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	6
	Current Month	0	0	0	0	0	0	6

Disenrollments TO Other Plans		Jan-13			Feb-12 to Jan-13		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	0	0	1	2	3
	VOL.	9	85	94	137	1,310	1,447
Affinity Health Plan	TOTAL	9	85	94	138	1,312	1,450
	INVOL.	0	0	0	3	19	22
	VOL.	22	162	184	212	2,480	2,692
Amerigroup/Health Plus/CarePlus	TOTAL	22	163	185	215	2,500	2,715
	INVOL.	0	0	0	0	20	20
	VOL.	84	633	717	743	6,244	6,987
Fidelis Care	TOTAL	84	633	717	743	6,264	7,007
	INVOL.	0	2	2	3	32	35
	VOL.	55	765	820	744	8,448	9,192
Health First	TOTAL	55	767	822	747	8,481	9,228
	INVOL.	0	0	0	0	3	3
	VOL.	5	82	87	129	989	1,118
HIP/NYC	TOTAL	5	82	87	131	992	1,123
	INVOL.	0	0	0	1	4	5
	VOL.	4	115	119	139	1,393	1,532
Neighborhood Health	TOTAL	4	115	119	140	1,398	1,538
	INVOL.	0	0	0	0	6	6
	VOL.	16	84	100	144	1,088	1,232
United Healthcare of NY	TOTAL	16	84	100	144	1,094	1,238
	INVOL.	0	0	0	2	11	13
	VOL.	5	27	32	30	322	352
Wellcare of NY	TOTAL	5	27	32	32	333	365
	INVOL.	0	2	2	10	97	107
	VOL.	200	1,953	2,153	2,278	22,274	24,552
Disenrolled Plan Transfers:	TOTAL	200	1,956	2,156	2,290	22,374	24,664
	INVOL.	3	22	25	54	558	612
	VOL.	5	59	64	171	1,003	1,174
Disenrolled Unknown Plan Transfers:	TOTAL	8	81	89	225	1,563	1,788
	INVOL.	138	3,967	4,105	11,438	108,985	120,423
	UNK.	0	1	1	33	93	126
	VOL.	0	25	25	88	1,605	1,693
Non-Transfer Disenroll Total:	TOTAL	138	3,993	4,131	11,559	110,683	122,242
	INVOL.	141	3,991	4,132	11,502	109,640	121,142
	UNK.	0	2	2	35	98	133
	VOL.	205	2,037	2,242	2,537	24,882	27,419
Total MetroPlus Disenrollment:	**TOTAL**	**346**	**6,030**	**6,376**	**14,074**	**134,620**	**148,694**

Disenrollments FROM Other Plans	Jan-13			Feb-12 to Jan-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	19	152	171	254	2,485	2,739
Amerigroup/Health Plus/CarePlus	24	211	235	535	4,553	5,088
Fidelis Care	6	164	170	175	2,403	2,578
Health First	14	147	161	194	2,372	2,566
HIP/NYC	6	78	84	80	1,263	1,343
Neighborhood Health	18	131	149	227	2,130	2,357
United Healthcare of NY	5	80	85	108	1,279	1,387
Wellcare of NY	5	91	96	221	1,334	1,555
Total	97	1,054	1,151	1,794	17,819	19,613
Unknown (not in total)	1,411	9,293	10,704	22,384	137,166	159,550

Data Source: RDS Report 1268a&c Updated 01/16/2013

Net Difference	Jan-13			Feb-12 to Jan-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	10	67	77	116	1,173	1,289
Amerigroup/Health Plus/CarePlus	2	48	50	320	2,053	2,373
Fidelis Care	-78	-469	-547	-568	-3,861	-4,429
Health First	-41	-620	-661	-553	-6,109	-6,662
HIP/NYC	1	-4	-3	-51	271	220
Neighborhood Health	14	16	30	87	732	819
United Healthcare of NY	-11	-4	-15	-36	185	149
Wellcare of NY	0	64	64	189	1,001	1,190
Total	-103	-902	-1,005	-496	-4,555	-5,051



MetroPlus Health Plan

New Member Transfer From Other Plans

	2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_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	
Affinity Health Plan	18	191	20	254	30	242	38	296	26	239	21	180	23	199	22	212	15	202	15	190	7	128	19	152	2,739
Amerigroup/Health Plus/CarePlus	43	346	55	558	63	494	77	614	74	549	44	372	47	342	30	333	20	263	36	282	22	189	24	211	5,088
Fidelis Care	10	170	16	208	17	190	27	224	11	199	5	159	22	221	14	215	11	209	24	285	12	159	6	164	2,578
Health First	8	188	17	250	20	214	19	253	25	213	13	212	20	244	22	177	13	165	18	192	5	117	14	147	2,566
HIP/NYC	8	89	10	128	7	117	5	130	7	130	9	95	7	112	8	128	4	97	4	106	5	53	6	78	1,343
Neighborhood Health Provider PHPS	18	166	18	233	22	190	30	250	32	200	15	140	16	185	13	186	13	144	19	195	13	110	18	131	2,357
United Healthcare of NY	14	89	10	126	10	90	11	161	10	144	10	96	6	95	14	92	9	98	5	118	4	90	5	80	1,387
Unknown PLan	2,152	13,040	2,066	11,413	1,914	10,654	2,476	14,769	2,180	12,020	1,950	11,514	2,029	13,342	1,692	10,659	1,524	9,371	1,789	13,733	1,201	7,358	1,411	9,293	159,550
Wellcare of NY	14	98	31	122	23	145	15	185	27	146	19	84	32	137	13	91	16	79	18	86	8	70	5	91	1,555
TOTAL	2,285	14,377	2,243	13,292	2,106	12,336	2,698	16,882	2,392	13,840	2,086	12,852	2,202	14,877	1,828	12,093	1,625	10,628	1,928	15,187	1,277	8,274	1,508	10,347	179,163

Report ID: MHP1268C
Report Run Date: 1/15/2013

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2013

Other Plan Name	Category	2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_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	
Affinity Health Plan	INVOLUNTARY	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	3
	VOLUNTARY	15	90	6	71	7	130	14	128	13	116	10	112	13	114	11	133	11	93	21	151	7	87	9	85	1,447
	TOTAL	15	90	6	71	7	130	14	129	13	116	10	113	13	114	11	133	11	93	21	151	8	87	9	85	1,450
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	0	1	0	2	0	3	0	2	1	4	0	1	0	2	2	1	0	1	0	0	0	2	0	0	22
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	VOLUNTARY	18	266	14	128	20	198	33	189	22	267	11	242	19	239	11	234	14	180	17	209	11	166	22	162	2,692
	TOTAL	18	267	14	130	20	201	33	191	23	271	11	243	19	241	13	235	14	181	17	209	11	168	22	163	2,715
Fidelis Care	INVOLUNTARY	0	2	0	0	0	1	0	1	0	1	0	4	0	2	0	0	0	2	0	1	0	6	0	0	20
	VOLUNTARY	33	268	17	148	22	265	28	273	26	240	77	564	149	989	99	792	89	652	79	873	40	547	84	633	6,987
	TOTAL	33	270	17	148	22	266	28	274	26	241	77	568	149	991	99	792	89	654	79	874	40	553	84	633	7,007
Health First	INVOLUNTARY	0	1	1	0	1	3	0	3	0	3	0	5	0	4	0	0	0	5	0	2	1	4	0	2	35
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	42	549	30	300	54	478	62	636	46	602	76	781	114	996	69	909	60	834	74	935	62	663	55	765	9,192
	TOTAL	42	550	31	300	55	481	62	639	46	605	76	787	114	1,000	69	909	60	839	74	937	63	667	55	767	9,228
HIP/NYC	INVOLUNTARY	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	3
	UNKNOWN	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	VOLUNTARY	9	92	9	54	14	112	14	98	15	83	11	84	6	84	10	90	13	53	17	89	6	68	5	82	1,118
	TOTAL	11	93	9	54	14	113	14	98	15	83	11	84	6	84	10	91	13	53	17	89	6	68	5	82	1,123
Neighborhood Health Provider	INVOLUNTARY	0	1	0	0	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	5
	UNKNOWN	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2013

		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_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	
Neighborhood Health Provider	VOLUNTARY	11	122	7	75	14	94	13	139	17	106	8	119	23	140	13	133	10	122	14	169	5	59	4	115	1,532
	TOTAL	11	123	7	76	14	95	13	139	17	106	8	119	23	141	14	133	10	122	14	170	5	59	4	115	1,538
United Healthcare of NY	INVOLUNTARY	0	0	0	1	0	1	0	0	0	0	0	1	0	2	0	0	0	0	0	0	0	1	0	0	6
	VOLUNTARY	8	82	7	51	8	68	12	103	11	69	13	110	18	129	11	91	7	84	21	142	12	75	16	84	1,232
	TOTAL	8	82	7	52	8	69	12	103	11	69	13	111	18	131	11	91	7	84	21	142	12	76	16	84	1,238
Wellcare of NY	INVOLUNTARY	0	0	0	0	0	1	2	5	0	0	0	2	0	1	0	0	0	1	0	1	0	0	0	0	13
	VOLUNTARY	2	26	2	13	1	17	3	27	0	30	4	14	2	38	3	30	3	31	3	45	2	24	5	27	352
	TOTAL	2	26	2	13	1	18	5	32	0	30	4	16	2	39	3	30	3	32	3	46	2	24	5	27	365
Disenrolled Plan Transfers	INVOLUNTARY	0	6	1	3	1	11	2	12	1	8	0	14	0	12	3	2	0	9	0	5	2	13	0	2	107
	UNKNOWN	2	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	5
	VOLUNTARY	138	1,495	92	840	140	1,362	179	1,593	150	1,513	210	2,026	344	2,729	227	2,412	207	2,049	246	2,613	145	1,689	200	1,953	24,552
	TOTAL	140	1,501	93	844	141	1,373	181	1,605	151	1,521	210	2,041	344	2,741	230	2,414	207	2,058	246	2,618	147	1,702	200	1,956	24,664
Disenrolled Unknown Plan Transfers	INVOLUNTARY	4	36	6	31	7	84	8	59	3	33	11	34	2	33	4	20	1	93	5	32	0	81	3	22	612
	UNKNOWN	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	VOLUNTARY	7	76	18	65	26	74	5	38	34	102	10	71	22	106	16	106	8	86	14	136	6	84	5	59	1,174
	TOTAL	11	113	24	97	33	158	13	97	37	135	21	105	24	139	20	126	9	179	19	168	6	165	8	81	1,788
Non-Transfer Disenroll Total	INVOLUNTARY	1,018	10,237	1,252	10,186	1,062	9,786	1,077	9,304	1,270	10,972	971	9,738	1,191	9,733	1,194	10,146	888	8,875	1,226	10,560	151	5,481	138	3,967	120,423
	UNKNOWN	1	14	2	13	2	15	3	9	5	5	8	6	5	2	2	4	3	15	2	5	0	4	0	1	126
	VOLUNTARY	1	63	78	781	2	98	7	133	0	92	0	76	0	69	0	81	0	57	0	80	0	50	0	25	1,693
	TOTAL	1,020	10,314	1,332	10,980	1,066	9,899	1,087	9,446	1,275	11,069	979	9,820	1,196	9,804	1,196	10,231	891	8,947	1,228	10,645	151	5,535	138	3,993	122,242

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 01/14/2013

		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_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**	1,022	10,279	1,259	10,220	1,070	9,881	1,087	9,375	1,274	11,013	982	9,786	1,193	9,778	1,201	10,168	889	8,977	1,231	10,597	153	5,575	141	3,991	121,142
	UNKNOWN	3	15	2	15	2	15	3	9	5	5	8	7	5	2	2	4	3	15	2	5	0	4	0	2	133
	VOLUNTARY	146	1,634	188	1,686	168	1,534	191	1,764	184	1,707	220	2,173	366	2,904	243	2,599	215	2,192	260	2,829	151	1,823	205	2,037	27,419
	TOTAL	1,171	11,928	1,449	11,921	1,240	11,430	1,281	11,148	1,463	12,725	1,210	11,966	1,564	12,684	1,446	12,771	1,107	11,184	1,493	13,431	304	7,402	346	6,030	148,694

Meaningful Use Update

Stage 2

What Stage 2 Means to Us

- New Criteria – Starting in 2014, providers participating in the EHR Incentive Programs who have met Stage 1 for two or three years will need to meet meaningful use Stage 2 criteria
- Improving Patient Care – Stage 2 includes new objectives to improve patient care through better clinical decision support, care coordination and patient engagement
- Saving Money, Time, Lives – With this next stage, EHRs will further save our health care system money, save time for doctors and hospitals, and save lives

Core Objectives

Core Objective	Measure Stage 1	Measure Stage 2
1. CPOE	**30%** medication	Use CPOE for **more than 60%** of medication, **30%** of laboratory, and **30%** of radiology
2. Demographics	**50%** demographics	Record demographics for more than **80%**
3. Vital Signs	**50%** vital signs over age 2	Record vital signs for **more than 80%**, blood pressure over age 3.
4. Smoking Status	**50%** smoking status	Record smoking status for **more than 80%**
5. Interventions	1 clinical support	Implement 5 clinical decision support interventions + drug/drug and drug/allergy
6. Labs	**40%** lab results	Incorporate lab results for **more than 55%**
7. Patient List	Same	Generate patient list by specific condition
8. eMAR	NEW	eMAR is implemented and used for **more than 10%** of medication orders
9 Transitions of Care Record	**50%** patients who request electronic copy are provided within 3 days.	Provided for more than 50% of transitions of care or referrals (does not have to be electronic) More than 10% are transmitted electronically • Care plan, including goals and instructions • List of team members, including PCP
10. Education Resources	Provide education resources. (previously a menu item)	Provide education resources **more than 10%** by certified EHR technology
11. Rx Reconciliation	Same (previously a menu item)	Medication reconciliation **at more than 50%** of transitions of care

Core Objectives

Core Objective	Measure Stage 1	Measure Stage 2
12. Summary of Care Record for Patient	(New)	Updated measure. Patients can View, Download, and transmit to a Third Party a summary of care document within 36 hours, 50% of the time and 5% of patients actually do so.
13. Immunizations	Perform 1 test on EHR to submit data (previously a menu item)	Successful ongoing transmission of immunization data
14. Reportable Labs	Perform 1 test on EHR to submit data (previously a menu item)	Successful ongoing submission of reportable laboratory results
15. Syndromic Surveillance	Perform 1 test on EHR to submit data (previously a menu item)	Successful ongoing submission of electronic syndromic surveillance data
16. Security Analysis	Conduct or review security analysis	Conduct or review security analysis and incorporate in risk management process addressing encryption of data

Menu Objectives (choose 3)

Menu Objective	Measure Stage 1	Measure Stage 2
1. Advanced Directives	**50%** of transactions of care.	Record advanced directives for **more than 50%** of patients 65 years or older
2. Progress Notes	NEW	Enter an electronic progress note for **more than 30%** of unique patients
3. Imaging Results	NEW	**More than 20%** of imaging results are accessible through Certified EHR Technology
4. Family History	NEW	Record family health history for **more than 20%**
5. E-Rx	NEW	**More than 10%** electronic prescribing (eRx) of discharge medication orders
6. Labs	NEW	Provide structured electronic lab results to EPs for **more than 20%**

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Engage patients and families in their health care

- More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge (Stage 1 was 10%, menu set)

- More than 5 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period (New)

Engage patients and families in their health care

- Clinical summaries provided to patients within 24 hours for more than 50 percent of office visits (Stage 1 was 3 days)

- More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology (Stage 1 was menu set)

- A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 percent of unique patients seen during the EHR reporting period (New – Eligible Provider)

Improve Care Coordination

- The eligible hospital or CAH performs **medication reconciliation** for more than 65 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) (Stage 1 was 50%, menu set)
- The eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides **a summary of care record** for more than 50 percent of transitions of care and referrals
- The eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care **electronically transmits a summary of care record** using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals (Stage 1 was one test of transmission)

Ensure adequate privacy and security protections for personal health information

- Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process (added data at rest)

CMS Final Rule – Hospital Definition of Meaningful Use

- Total of 22 Meaningful Use objectives:
  - 16 core items required for Stage 2
  - 3 of 6 menu items required for Stage 2
- Changes from Stage 1:
  - Most Stage 1 menu items now required
  - 7 new objectives added
  - Some related Stage 1 objectives combined
- Quality reporting now separate element of meaningful use

Clinical Quality Measures

Hospitals must report on 16 measures

Quality Measures include 29 measures in 6 domains

Reported measures must come from at least 3 domains of the 6 HHS National Quality Strategy domains:

- **Patient and Family Engagement (5)**
- **Patient Safety (6)**
- **Care Coordination (2)**
- **Population and Public Health (0)**
- **Efficient Use of Healthcare Resources (2)**
- **Clinical Processes/Effectiveness (14)**

The Road To MU Stage II

- QuadraMed Upgrades 5.4 and 6.0 (Target Q3, 2013)
- Cache Upgrade 2012 version
- BCMA Implementation (remaining sites)
- Medication Reconciliation Required
- Expand Electronic Access of Patient Information
- Update of Quality Reports
- Address Menu Items

  Progress Notes are Electronic >30 % of time

  Maintain Advanced Directive Assessments > 50%

  Third Menu (TBD-Awaiting Radiology Imaging Assessment)

Milestone Targets

- Maintain MU Stage 1 through 9/13
- Complete 6.0 by December, 2013
- Achieve MU Stage 2 continuously for 90 days in these Federal-FY Quarters:

  Jan-Mar 2014

  Apr-Jun 2014

  Jul-Sep 2014 (last chance!)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

QuadraMed
Quality Care. Financial Health.