AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: January 15th, 2015
Time: 9:00 AM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES
December 11, 2014

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

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

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 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 in conjunction with DSRIP. The contract shall be for a period of five years with two, consecutive, one-year options to renew, exercisable solely by the Corporation, in an amount not to exceed $35,441,897 for a total term of seven years. — **MRS. JOHNSTON**

INFORMATION ITEMS:

1. **Meaningful Use** — **MR. ROBLES/ MS. BARRAMEDA**

2. **e-Prescribing update** — **MR. ROBLES/ MS. BARRAMEDA**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: December 11, 2014

ATTENDEES

COMMITTEE MEMBERS

Vincent Calamia, MD, Committee Chair
Josephine Bolus, RN
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
(representing Dr. Ram Raju in a voting capacity)
Hillary Kunins, MD, Assistant Commissioner Drug and Alcohol, Health and Mental Hygiene
(representing Dr. Gary Belkin in a voting capacity)

HHC CENTRAL OFFICE STAFF:

Sharon Abbott, Assistant Director, Corporate Planning and HIV Services
Machelle Allen, MD, Deputy Chief Medical Officer, Office of Health Care Improvement
Jeremy Berman, Deputy Counsel, Legal Affairs
Maria Arias-Clarke, Assistant Director, Corporate Budget
Janette Baxter, Senior Director, Risk Management
Joe Bender, Assistant Director, Communication & Marketing
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
Kenra Ford, Assistant Vice President, Clinical Laboratory Operation
Juliet Gaengan, Senior Director, Quality & Innovation
Sal Guido, Assistant Vice President, Infrastructure Services
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
Michael Keil, Assistant Vice President, Enterprise IT Services
Patricia Lockhart, Secretary to the Corporation
Katarina Madej, Director, Communication & Marketing
Glenn Manjorin, Director, Enterprise It Service
Ana Marengo, Senior Vice President, Communications & Marketing
Deirdre Newton, Senior Counsel, Office of Legal Affairs
Bert Robles, Senior Vice President, Chief Information Officer
Deborah Rose, Director, Patient Center Care
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Lynnette Sainbert, Assistant Director, Board Affairs
Jared Sender, Enterprise Information Technology Service
David Shi, Senior Director, Medical & Professional Affairs
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:

Ernest Baptiste, Executive Director, Kings County Hospital
Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan

Anthony Rajkumar, Acting Executive Director, Metropolitan Hospital Center

OTHERS PRESENT
Mike Butler, OMB
Cherry Kent, OMB
Richard McIntyre, Siemens
Vamsee Sistla, Microsoft Tech Specialist
Kristyn Raffaele, Analyst, OMB
Dhruneanne Woodrooffe, Analyst OMB

MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, December 11, 2014

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 12:30 pm. The minutes of the November 6, 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.

Accountable Care Organization (HHC ACO)

ACO Clinical Leadership Teams at 18 hospitals, D&TCs, and Nursing Facilities gathered earlier this month to review 2014 population management efforts, exchange best practices, and review end-of-year and 2015 strategic priorities and goals. The group is eager to build upon the success of the ACO's strong 2013 performance in this second performance year, by continuing to focus on high-quality primary care, coordination across the system, and keeping our patients healthy and out of the hospital.

Quality Management leads from across HHC convened for the ACO's 2014 Quality Reporting Kickoff. Building upon successful 2013 efforts, each facility is developing their process and staffing plans for chart review, to be integrated with EMR data under the leadership of IT partners, to fully and accurately report our ACO quality performance.

Managed Care Readiness – Behavioral Health

As the transformation of Behavioral Health services is taking shape, in the context of DSRIP and "Managed Behavioral Health", the therapeutic role for individuals (peers) who have reached a point in their own recovery to help other consumers through their lived experience is increasingly recognized as important and effective.

As part of HHC further expanding its cadre of these peer counsellors, the Office of Behavioral Health held an event to provide education on opportunities in peer counseling and recovery coaching in Behavioral Health services. Approximately 100 consumers attended the event, which took place at Kings County Hospital Center. The event featured presentations by representatives of DOHMH and Howie the Harp as well as by several HHC Peer Counsellors. Vocational providers, including ACCES-VR, were also on hand, offering materials about specific training and employment programs. Attendees participated in breakout groups designed to elicit concepts and strategies for attaining educational and vocational goals. Consumers expressed tremendous interest and enthusiasm in opportunities to work.

OFFICE OF POPULATION HEALTH

Through the Teen Health Improvement Program, we are planning a conference in April of 2015 focusing on models for integrating behavioral health care into pediatric/adolescent primary care. We plan to launch a "YouthHealth" marketing campaign and website in the Spring, to raise awareness about the comprehensive services we offer for adolescents.

Other activities include:

Partnering with Health Leads, a program which enables physicians to refer patients to help for social needs, i.e. housing, food. We will be relaunching the program in 3 facilities and evaluating the impact. The Fruit and Vegetable Prescription program was featured in a New York Times story by Jane Brody on December 1; to reduce barriers to smoking cessation, we are distributing nicotine replacement therapy to provide at the point of care, and are working with IT to create automated referral to the New York State Quitline thru Quadramed. HHC is partnering with NYU in the re-application for a Clinical Translational Science Award from NIH. If awarded, the grant will provide funds to support a few research personnel at HHC.

FLU

There is ongoing vaccination of HHC's health care workforce, so far without the declaration of the flu season by NYS DOH. This declaration will trigger the use of masks by all staff who are not able to demonstrate their vaccination status as positive. The committee should also be aware of the recent CDC comments on the number of H3N2 (Infl A) strains that have been pathogenic so far this year, which may not be covered by the current vaccine. These comments in no way reduce the clinical and social imperative for all healthcare workers to be vaccinated against the flu.

DSRIP

HHC is on course to complete its DSRIP application by the December deadline. This will be a robust application with many community partners for our single PPS and its 4 borough hubs. There is an action item on today's agenda, which seeks ratification by the Board for management's actions in undertaking this application, as well as authorization for the use of an existing subsidiary company to undertake a central services role to support the operation of the PPS.

MetroPlus Health Plan, Inc.

Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of November 1, 2014 was 469,070. Breakdown of plan enrollment by line of business is as follows:

Medicaid	395,407
Child Health Plus	12,231
Family Health Plus	5,820
MetroPlus Gold	3,401
Partnership in Care (HIV/SNP)	4,954
Medicare	8,477
MLTC	774
QHP	37,318
SHOP	688

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 FHP membership is rolling into Medicaid, we will continue to see increases in the latter. However, the Medicaid membership increase experienced in the month of November was greater than the transfer (rollover) from FHP (same as in October). We have also seen a slight increase in the Exchange membership.

As you know, the Open Enrollment Period (OEP) started on November 15th. In addition to strategically pricing our products, we have taken numerous important steps in an effort to grow membership. We have been collaborating with HHC facilities in targeting 190,000 HHC self-pay patients who are potentially eligible for insurance, embarked on aggressive advertising and marketing campaigns emphasizing our relationship with HHC, as well as initiated an extensive member retention campaign.

One of the barriers we faced with the new Exchange line of business during last year's open enrollment period and thereafter, was that the State had no mechanism in place to allow us to assign PCPs to members. This lead to major customer dissatisfaction and extremely high call volume to our Customer Services department. For the current open enrollment, we have worked on a homegrown solution for MetroPlus staff and HHC HCIs whereby they can assign the PCP of the member's choice using the MetroPlus website.

We have also learned from the previous year's experience that our members were looking for easier ways to pay their premiums, select their PCP, view their account information online, etc. We listened to the voice of our members and

have therefore adapted our website, improving its functionality, thereby offering all those solutions at the click of a button.

Our Brooklyn community office opened on the first day of Open Enrollment. We have experienced a tremendous volume of walk-ins on the very first day, resulting in over 200 applications.

We have seen a high number of Exchange applicants during the first week of Open Enrollment. There was a total of 2,672 submitted applications, and 96 applications in progress for the period 11/15 thru 11/21/14.

During this first week of Open Enrollment, there were a total of 41,000 transactions and a total of 23,000 membership renewals. As of the date of this report, we cannot tell how many of the above referenced transactions are new members, changes to existing member information, cancellations, etc. I will have more accurate information to report at the next meeting.

As we look back at the first year operating under the new ACA Exchange product, I would like to summarize the year in numbers for this committee. The previous Open Enrollment Period (OEP) started on October 1, 2013, and ended on March 31, 2014. Anyone who enrolled before December 23, 2013, was effectuated as of January 1, 2014. The Exchange membership on January 1, 2014, was 13,025 (3% of total membership) and 27,978 as of April 1, 2014 (215% increase during Open Enrollment) and it represented 6.3% of total membership as of that date. The highest Exchange membership was in May 2014, at 44,311 members. Over the following few months, there have been slight decreases due to member non-payment.

The total membership as of January 1, 2014 was 432,791, representing an increase of almost 12,000 members from December 1, 2013 (an increase of 3% in one month). As of April 1, 2014, our total membership was 444,748 – the majority of members enrolled as follows: 362,939 or 82% in Medicaid and 27,978 or 7% in Exchange. As of this month, Medicaid increased to 84%, and Exchange to 8% of the total of 469,070 (a net increase of approximately 25,000 members – or 6% from December 2013).

As far as the MetroPlus Gold line of business, we have only seen a very small increase in membership over the course of this year (from 3,322 as of YE13 to 3,401 as of November 1, 2014 – an increase of 2%).

On a positive note, I concluded my last report by thanking and congratulating the MetroPlus Communications team for their innovative work that led to MetroPlus' award-winning performance in the 2014 American Health and Wellness Design Awards. I have obtained the award winning materials to share with this committee.

ACTION ITEM:

Ratifying the action taken by the New York City Health and Hospitals Corporation (the "Corporation") to (i) submit an application to the New York State Department of Health ("DOH") to participate in the Delivery System Reform Incentive Payment program ("DSRIP") pursuant to which the Corporation will establish a single Performing Provider System (a "PPS") in collaboration with various health care providers (the "Participants"); and

Authorizing the Corporation to (ii) enter into agreements within the PPS structure with those Participants listed on the attached Schedule of Participants designated as "City Wide" and those Participants designated as "Hub-Based" in the attached Schedule of Participants subject to the addition of additional Hub-Based Participants or the removal of some Hub-Based Participants at the discretion of the Corporation President as he determines to be necessary or appropriate to respond to evolving DOH requirements, guidance and regulations, and the Corporation's assessment of the ability of the Hub-Based Participants to perform as required for the DSRIP program; (iii) cause the HHC Assistance Corporation (the "CSO") to provide technical assistance to the PPS in the capacity of a centralized service organization; (iv) nominate from among the officers and senior managers of the Corporation the directors of the CSO provided that the Corporation President shall have the authority to nominate one or more directors of the CSO who are not officers or employees of the Corporation provided further that such outside directors never exceed 25% of the total of CSO

directors; (v) enter into such other and further ancillary contracts as are necessary or appropriate to carry out the purposes of the DSRIP program and to ensure the Corporation's successful execution of its DSRIP projects using the structure diagramed in the attached Table of Organization; and

Directing the Corporation to (vi) subject the activities of the CSO under the DSRIP program to the Corporation's compliance and internal audit programs; (vii) requiring that all procurement contracts of the CSO be subject to the procurement rules applicable to the Corporation; and (viii) make regular, periodic reports to the Corporation's Board of the progress of the DSRIP application and the implementation of the DSRIP projects including an overview of all contracts made by either CSO or the Corporation to carry out the DSRIP program.

Resolution approved by the Board.

INFORMATION ITEMS

Michael Keil – Assistant Vice President, IT Service Management Office

EITS Business Continuity Program (ITDR/BCM)
Review (Established 2011). The foundation for a Business Continuity Management program is comprised of several components: Understanding the Operationally Critical Business processes and the IT resources required. Business Impact Analysis (BIA) completed (2011) with 35 critical apps identified. Engaged the ITPMC with Methodology documented and used moving forward in the EPIC implementation. Establishing a DR recovery prioritization chart with Recovery Time Objectives (RTO) & Recovery Point Objectives (RPO). Tiering prioritization for the top 35 clinical applications developed and reviewed/published. Annual review continues as HHC business needs change.

EITS Business Continuity Program (ITDR/BCM)
Establishing a Disaster Recovery (DR) testing methodology to apply repeatable procedures throughout all IT infrastructure. Standardized DR Guides for QCPR, Application Recovery Plans written for Key applications
Financial application templates and owner participation, Project Plans written for each exercise event
Conducting periodic tests to ensure the quality of the program meets the needs of the organization.
All eight QCPR domains have been exercised for full Failover and Failback, Financial applications have been exercised on an annual basis. Selected critical ancillary applications have been exercised in preparation for EPIC implementation
All exercises now documented with Project Management Program and Homeland Security Standard forms
Identifying and preparing for the risks and vulnerabilities for recovery at our facilities.

An analysis was done for 2013 and updated to 2014 for Tiers 1 thru Tier 4, the systems are still being tested on worked on.

Target Completion: June 2015

Recovery Plan	Current Status
IT Business Continuity Management Plan	1 / 1
Facility Coordination Plans	7 / 7
Tiered Application Recovery Plans **2013** Discovered Dependent Plans **2014**	28 / 35 110 / 180

Infrastructure Recovery Plans	5 / 5

Business Continuity Program Next Steps
Develop auditor approved BCM Planning template document
Develop educational strategy for EITS regarding BCM
EITS RISK Management strategy and metrics (Risk and BIA)
Improved Working relationship with HHC OEM on related solutions:
Crisis Management software discovery and deployment(NC4)
SendWordNow Communication software discovery and deployment
Business Continuity Software management (Sustainable Planner – Virtual Corp)

He also touched on the Disaster Recovery Maturity – Self Assessment, and Program Time Line.

There being no further business, the meeting was adjourned at 1:30 pm.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
January 15, 2015

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.

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 12/14/2014

Other Plan Name	Category	2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		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	1	1	2	1	4	0	3	1	3	1	1	1	4	0	6	0	9	1	2	0	1	0	7	50
	VOLUNTARY	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	TOTAL	1	1	1	2	1	4	1	3	1	3	1	1	1	4	0	6	0	9	1	2	0	1	0	7	51
Affinity Health Plan	INVOLUNTARY	0	4	3	29	1	3	1	16	11	90	0	19	5	93	3	20	1	23	0	20	0	38	0	28	408
	VOLUNTARY	8	77	7	52	10	76	10	104	0	1	4	79	0	0	7	52	6	93	6	53	3	61	0	43	752
	TOTAL	8	81	10	81	11	79	11	120	11	91	4	98	5	93	10	72	7	116	6	73	3	99	0	71	1,160
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	4	6	5	54	1	13	0	25	12	165	1	44	6	128	0	46	0	56	0	45	3	55	0	50	719
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	15	160	1	74	9	143	6	182	0	0	10	148	0	1	5	80	2	115	0	67	1	98	4	93	1,214
	TOTAL	19	166	6	128	10	156	6	207	12	165	11	192	6	130	5	126	2	171	0	112	4	153	4	143	1,934
BC/BS OF MNE	INVOLUNTARY	2	0	0	5	2	6	0	9	1	6	1	12	1	11	1	10	0	20	1	7	3	12	0	10	120
	VOLUNTARY	0	1	0	0	1	1	1	1	0	0	1	1	0	0	0	1	0	0	0	0	0	1	0	2	11
	TOTAL	2	1	0	5	3	7	1	10	1	6	2	13	1	11	1	11	0	20	1	7	3	13	0	12	131
CIGNA	INVOLUNTARY	0	1	1	4	0	4	0	3	0	5	0	1	0	1	1	4	0	0	0	0	0	2	0	1	28
	VOLUNTARY	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	3
	TOTAL	0	2	1	4	1	4	0	3	0	5	0	1	0	1	1	4	0	1	0	0	0	2	0	1	31
Fidelis Care	INVOLUNTARY	2	6	19	191	0	30	2	52	48	429	1	101	20	393	5	134	3	146	4	149	0	161	0	131	2,027
	UNKNOWN	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1	0	4
	VOLUNTARY	40	424	8	162	40	404	34	454	0	0	42	416	0	0	10	315	22	405	16	303	11	334	8	346	3,794
	TOTAL	42	430	27	354	40	434	36	506	48	429	44	517	20	393	15	449	25	551	20	452	11	496	9	477	5,825

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 12/14/2014

		2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		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	0	0	6	0	4	0	4	1	4	0	3	0	7	0	3	1	3	0	2	0	2	0	4	44
	VOLUNTARY	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	5
	TOTAL	0	1	0	6	0	4	1	5	1	4	0	3	0	7	0	3	1	5	0	2	0	2	0	4	49
Health First	INVOLUNTARY	0	15	32	309	1	46	2	90	40	696	9	185	26	657	1	174	5	189	5	231	3	255	1	189	3,161
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	1	1	1	0	0	0	1	6
	VOLUNTARY	58	594	8	275	47	633	48	755	0	2	39	750	0	0	25	520	18	733	17	521	12	564	11	649	6,279
	TOTAL	58	609	40	584	48	679	50	845	40	698	49	935	26	657	27	694	23	923	23	753	15	819	12	839	9,446
HEALTH INS PLAN OF GREATER NY	INVOLUNTARY	0	0	0	2	1	1	0	2	0	1	0	0	0	3	0	3	0	2	0	2	1	1	0	3	22
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	2
	TOTAL	0	0	0	2	1	1	0	2	0	1	0	0	0	4	0	3	0	2	0	3	1	1	0	3	24
HIP/NYC	INVOLUNTARY	0	4	1	33	1	4	0	14	4	56	0	21	1	71	0	18	0	20	0	28	0	24	0	21	321
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	2
	VOLUNTARY	5	73	2	39	2	55	5	81	0	1	2	58	0	0	1	33	2	37	2	37	1	33	1	29	499
	TOTAL	5	77	3	72	3	59	5	95	4	57	2	79	1	71	1	51	3	57	2	65	1	57	1	51	822
OXFORD INSURANCE CO.	INVOLUNTARY	0	0	0	0	0	0	1	1	0	2	0	0	1	1	1	2	0	6	0	2	0	2	0	2	21
	VOLUNTARY	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
	TOTAL	0	0	0	0	0	0	1	2	0	2	0	1	1	1	1	2	0	6	0	2	0	2	0	2	23
UNION LOC. 1199	INVOLUNTARY	0	5	7	21	0	8	2	5	4	12	1	4	1	8	0	4	1	1	0	0	1	1	0	6	92
	VOLUNTARY	9	7	0	0	1	12	5	15	0	0	1	10	0	0	1	14	8	23	5	6	1	9	0	7	134
	TOTAL	9	12	7	21	1	20	7	20	4	12	2	14	1	8	1	18	9	24	5	6	2	10	0	13	226

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 12/14/2014

		2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		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	10	1	48	0	10	1	24	3	86	1	33	6	71	0	41	1	44	0	59	2	50	1	49	542
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	2
	VOLUNTARY	8	76	2	30	4	99	8	81	0	1	7	65	0	0	2	39	1	63	3	38	0	32	0	61	620
	TOTAL	9	86	3	78	4	109	9	105	3	87	9	98	6	71	3	80	2	107	3	97	2	82	1	110	1,164
Wellcare of NY	INVOLUNTARY	1	6	2	17	2	1	0	16	1	25	2	18	9	42	1	10	0	30	1	26	0	31	0	19	260
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
	VOLUNTARY	0	23	2	9	2	16	1	20	0	0	0	12	0	0	0	26	3	21	5	14	1	13	0	15	183
	TOTAL	1	29	4	26	4	17	1	36	1	25	2	30	11	42	1	36	3	51	6	40	1	44	0	34	445
Disenrolled Plan Transfers	INVOLUNTARY	11	58	72	721	10	134	9	264	126	1,580	17	442	77	1,490	13	475	12	549	12	573	13	635	2	520	7,815
	UNKNOWN	0	0	0	1	0	0	0	0	0	0	3	0	2	1	2	0	1	1	1	1	0	1	1	2	17
	VOLUNTARY	143	1,437	30	641	117	1,439	120	1,695	0	5	106	1,540	0	2	51	1,080	62	1,493	54	1,040	30	1,145	24	1,245	13,499
	TOTAL	154	1,495	102	1,363	127	1,573	129	1,959	126	1,585	126	1,982	79	1,493	66	1,555	75	2,043	67	1,614	43	1,781	27	1,767	21,331
Disenrolled Unknown Plan Transfers	INVOLUNTARY	1	28	2	76	1	27	8	29	4	71	4	53	5	129	1	34	1	60	3	29	5	53	2	31	657
	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	1	56	1	19	0	38	1	33	0	10	0	54	0	18	1	42	0	58	2	81	0	72	0	51	538
	TOTAL	2	84	3	95	1	65	9	62	4	81	4	108	5	147	2	76	1	118	5	110	5	125	2	82	1,196
Non-Transfer Disenroll Total	INVOLUNTARY	1,060	10,877	741	11,883	793	10,699	1,012	11,450	950	11,436	860	10,582	850	10,499	799	10,899	779	9,807	1,068	10,449	1,305	9,884	402	8,705	137,789
	UNKNOWN	45	0	2	6	2	1	13	13	14	12	22	15	29	22	34	46	10	48	1	55	13	32	0	11	446
	VOLUNTARY	3	71	0	46	2	80	2	88	0	47	2	83	0	107	1	88	3	69	2	74	4	58	1	100	931
	TOTAL	1,108	10,948	743	11,935	797	10,780	1,027	11,551	964	11,495	884	10,680	879	10,628	834	11,033	792	9,924	1,071	10,578	1,322	9,974	403	8,816	139,166

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 12/14/2014

		2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		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**	1,072	10,963	815	12,680	804	10,860	1,029	11,743	1,080	13,087	881	11,077	932	12,118	813	11,408	792	10,416	1,083	11,051	1,323	10,572	406	9,256	146,261
	UNKNOWN	45	0	2	7	2	1	13	13	14	12	25	16	31	23	36	46	11	49	2	56	13	33	1	13	464
	VOLUNTARY	147	1,564	31	706	119	1,557	123	1,816	0	62	108	1,677	0	127	53	1,210	65	1,620	58	1,195	34	1,275	25	1,396	14,968
	TOTAL	1,264	12,527	848	13,393	925	12,418	1,165	13,572	1,094	13,161	1,014	12,770	963	12,268	902	12,664	868	12,085	1,143	12,302	1,370	11,880	432	10,665	161,693

MetroPlus Health Plan

New Member Transfer From Other Plans

	2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		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	1	17	4	13	2	6	1	6	0	3	1	4	0	3	0	8	0	6	0	7	1	9	0	8	100
Affinity Health Plan	6	145	5	114	6	106	10	119	8	113	7	112	1	88	3	95	5	102	2	87	1	87	2	118	1,342
Amerigroup/Health Plus/CarePlus	16	189	7	165	11	205	16	173	8	141	7	186	5	119	3	115	5	135	3	96	0	93	0	142	1,840
BC/BS OF MNE	0	37	4	19	2	14	5	14	0	6	1	11	0	7	0	19	0	30	0	25	0	49	0	45	288
CIGNA	1	15	1	9	2	3	3	7	0	3	0	5	0	6	0	0	0	1	0	4	0	1	0	1	62
Fidelis Care	4	152	3	130	15	151	10	188	5	163	10	144	9	146	6	115	6	138	2	117	0	97	0	113	1,724
GROUP HEALTH INC.	1	20	0	11	1	9	1	13	0	10	0	11	0	2	0	5	0	13	0	9	0	4	0	8	118
Health First	7	189	9	123	5	151	15	166	7	127	8	159	7	146	4	134	2	182	1	129	3	131	0	196	1,901
HEALTH INS PLAN OF GREATER N	0	13	0	14	2	7	2	8	0	2	0	5	0	3	0	8	0	8	1	3	0	10	0	15	101
HIP/NYC	2	55	2	69	1	60	2	74	2	64	1	72	2	43	0	36	0	53	0	55	0	50	0	52	695
OXFORD INSURANCE CO.	1	13	0	3	1	5	0	6	0	3	0	2	0	5	1	2	0	7	0	0	0	4	0	5	58
UNION LOC. 1199	7	37	3	18	5	6	8	27	4	19	1	21	2	8	2	12	1	18	0	17	3	3	0	6	228
United Healthcare of NY	3	89	7	77	10	72	4	92	3	56	5	66	0	54	0	43	0	57	0	56	0	64	1	54	813
Unknown Plan	1,042	14,813	1,112	6,298	1,137	5,655	945	7,268	161	4,755	71	6,032	15	4,724	9	4,364	5	5,219	14	4,807	3	5,170	8	5,907	79,534
Wellcare of NY	9	97	5	98	11	82	9	122	6	103	6	82	1	52	3	52	2	57	1	48	0	37	1	53	937
TOTAL	1,100	15,881	1,162	7,161	1,211	6,532	1,031	8,283	204	5,568	118	6,912	42	5,406	31	5,008	26	6,026	24	5,460	11	5,809	12	6,723	89,741

Report ID: MHP1268C
Report Run Date: 12/15/2014

Management Indicator Report # 1

For Enrollment Month 201412

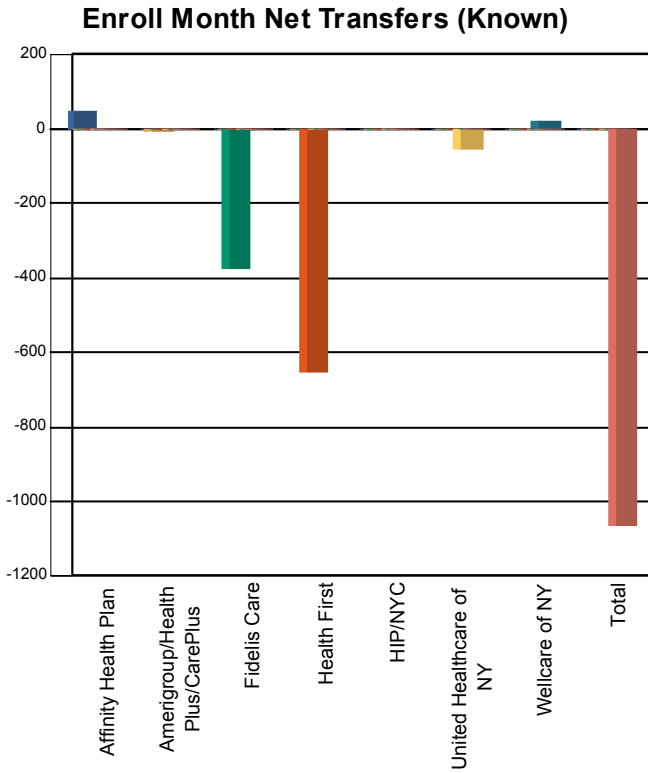
Indicator #1A for Enrollment Month: December 2014

Disenrollments To Other Plans

		Enrollment Mont			Twelve Months Period		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOLUNTARY		28	28	25	383	408
	VOLUNTARY		43	43	61	691	752
Affinity Health Plan	**TOTAL**		**71**	**71**	**86**	**1074**	**1160**
	INVOLUNTARY		50	50	32	687	719
	VOLUNTARY	4	93	97	53	1161	1214
Amerigroup/Health Plus/CarePlus	**TOTAL**	**4**	**143**	**147**	**85**	**1848**	**1933**
	INVOLUNTARY		131	131	104	1923	2027
	UNKNOWN	1		1	2	2	4
	VOLUNTARY	8	346	354	231	3563	3794
Fidelis Care	**TOTAL**	**9**	**477**	**486**	**337**	**5488**	**5825**
	INVOLUNTARY	1	189	190	125	3036	3161
	UNKNOWN		1	1	3	3	6
	VOLUNTARY	11	649	660	283	5996	6279
Health First	**TOTAL**	**12**	**839**	**851**	**411**	**9035**	**9446**
	INVOLUNTARY		21	21	7	314	321
	UNKNOWN		1	1	1	1	2
	VOLUNTARY	1	29	30	23	476	499
HIP/NYC	**TOTAL**	**1**	**51**	**52**	**31**	**791**	**822**
	INVOLUNTARY	1	49	50	17	525	542
	VOLUNTARY		61	61	35	585	620
United Healthcare of NY	**TOTAL**	**1**	**110**	**111**	**52**	**1110**	**1162**
	INVOLUNTARY		19	19	19	241	260
	VOLUNTARY		15	15	14	169	183
Wellcare of NY	**TOTAL**		**34**	**34**	**33**	**410**	**443**
	INVOLUNTARY	2	520	522	374	7441	7815
	UNKNOWN	1	2	3	10	7	17
	VOLUNTARY	24	1245	1269	737	12762	13499
Disenrolled Plan Transfers	**TOTAL**	**27**	**1767**	**1794**	**1121**	**20210**	**21331**
	INVOLUNTARY	2	31	33	37	620	657
	VOLUNTARY		51	51	6	532	538
Disenrolled Unknown Plan Transfers:	**TOTAL**	**2**	**82**	**84**	**43**	**1152**	**1195**
	INVOLUNTARY	402	8705	9107	10619	127170	137789
	UNKNOWN		11	11	185	261	446
	VOLUNTARY	1	100	101	20	911	931
Non-Transfer Disenroll Total:	**TOTAL**	**403**	**8816**	**9219**	**10824**	**128342**	**139166**
	INVOLUNTARY	406	9256	9662	11030	135231	146261
	UNKNOWN	1	13	14	195	269	464
	VOLUNTARY	25	1396	1421	763	14205	14968
Total MetroPlus Disenrollment:	**TOTAL**	**432**	**10665**	**11097**	**11988**	**149705**	**161693**

Net Difference

	Enrollment Month			Twelve Months Period		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan		47	49	-30	212	182
Amerigroup/Health Plus/CarePlus		-1	-5	-4	-89	-93
Fidelis Care		-364	-373	-267	-3,834	-4,101
Health First		-643	-655	-343	-7,202	-7,545
HIP/NYC		1	0	-19	-108	-127
United Healthcare of NY	0	-56	-56	-19	-330	-349
Wellcare of NY		19	20	21	473	494
Total	-23	-1,039	-1,062	-747	-11,332	-12,079



MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

December-2014

		Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Total Members	Prior Month	467,662	468,032	465,725	464,114	466,626	467,894	470,237
	New Member	19,555	17,364	17,662	20,370	19,273	19,421	18,222
	Voluntary Disenroll	2,062	349	1,503	1,971	1,491	1,626	1,676
	Involuntary Disenroll	17,123	19,322	17,770	15,887	16,514	15,452	13,728
	Adjusted	34	60	116	-393	507	1,639	0
	Net Change	370	-2,307	-1,611	2,512	1,268	2,343	2,818
	Current Month	468,032	465,725	464,114	466,626	467,894	470,237	473,055
Medicaid	Prior Month	370,764	375,282	378,098	381,067	386,999	391,647	396,922
	New Member	17,308	15,100	15,642	18,027	16,963	17,174	16,487
	Voluntary Disenroll	1,678	127	1,210	1,619	1,195	1,275	1,396
	Involuntary Disenroll	11,112	12,157	11,463	10,476	11,120	10,624	9,302
	Adjusted	27	58	117	-394	486	1,532	0
	Net Change	4,518	2,816	2,969	5,932	4,648	5,275	5,789
	Current Month	375,282	378,098	381,067	386,999	391,647	396,922	402,711
Child Health Plus	Prior Month	11,913	11,877	11,700	11,685	11,837	12,072	12,237
	New Member	491	449	490	679	834	692	617
	Voluntary Disenroll	51	56	51	68	49	95	96
	Involuntary Disenroll	476	570	454	459	550	432	467
	Adjusted	1	2	2	3	9	6	0
	Net Change	-36	-177	-15	152	235	165	54
	Current Month	11,877	11,700	11,685	11,837	12,072	12,237	12,291
Family Health Plus	Prior Month	22,796	20,145	17,552	14,962	12,408	9,421	5,881
	New Member	109	42	35	23	23	14	11
	Voluntary Disenroll	108	0	53	65	58	34	25
	Involuntary Disenroll	2,652	2,635	2,572	2,512	2,952	3,520	2,357
	Adjusted	1	0	-1	-2	-3	61	0
	Net Change	-2,651	-2,593	-2,590	-2,554	-2,987	-3,540	-2,371
	Current Month	20,145	17,552	14,962	12,408	9,421	5,881	3,510

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

December-2014

		Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
HHC	Prior Month	3,419	3,443	3,515	3,520	3,549	3,431	3,432
	New Member	50	136	57	56	60	20	9
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	26	64	52	27	178	19	36
	Adjusted	5	1	1	2	15	31	0
	Net Change	24	72	5	29	-118	1	-27
	Current Month	3,443	3,515	3,520	3,549	3,431	3,432	3,405
SNP	Prior Month	5,217	5,230	5,252	5,198	5,096	5,017	4,969
	New Member	131	129	73	58	51	66	53
	Voluntary Disenroll	56	8	40	78	36	52	28
	Involuntary Disenroll	62	99	87	82	94	62	49
	Adjusted	0	0	0	3	3	15	0
	Net Change	13	22	-54	-102	-79	-48	-24
	Current Month	5,230	5,252	5,198	5,096	5,017	4,969	4,945
Medicare	Prior Month	8,117	7,938	8,142	8,250	8,344	8,393	8,474
	New Member	330	462	364	336	306	359	292
	Voluntary Disenroll	167	158	149	139	153	169	131
	Involuntary Disenroll	342	100	107	103	104	109	87
	Adjusted	0	-1	-1	-2	-2	-6	0
	Net Change	-179	204	108	94	49	81	74
	Current Month	7,938	8,142	8,250	8,344	8,393	8,474	8,548
Managed Long Term Care	Prior Month	535	575	606	629	675	725	776
	New Member	52	44	39	58	66	85	55
	Voluntary Disenroll	1	0	0	0	0	1	0
	Involuntary Disenroll	11	13	16	12	16	33	21
	Adjusted	0	0	-2	-1	0	2	0
	Net Change	40	31	23	46	50	51	34
	Current Month	575	606	629	675	725	776	810

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

December-2014

		Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
QHP	Prior Month	44,316	42,907	40,206	38,119	37,005	36,462	36,810
	New Member	1,015	952	908	1,086	932	986	679
	Voluntary Disenroll	1	0	0	2	0	0	0
	Involuntary Disenroll	2,423	3,653	2,995	2,198	1,475	638	1,403
	Adjusted	0	0	0	-2	-1	-2	0
	Net Change	-1,409	-2,701	-2,087	-1,114	-543	348	-724
	Current Month	42,907	40,206	38,119	37,005	36,462	36,810	36,086
SHOP	Prior Month	585	635	654	684	713	726	736
	New Member	69	50	54	47	38	25	19
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	19	31	24	18	25	15	6
	Adjusted	0	0	0	0	0	0	0
	Net Change	50	19	30	29	13	10	13
	Current Month	635	654	684	713	726	736	749

RESOLUTION

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).

WHEREAS, the Corporation requires a CCMS to allow both internal and network providers and teams to manage and to coordinate the medical and non-medical services and resources patients may require to be successful in reaching their goals, consistent with and in support of the Corporation's DSRIP strategy; and

WHEREAS, the Corporation seeks to enter into a contract to provide a CCMS to support care coordination services for HHC patients throughout the five boroughs of New York City,; and

WHEREAS, a Request for Proposals ("RFP") was issued on September 11, 2014; the selection committee, which rated the proposals using criteria specified in the RFP, recommended that GSI Health be awarded the contract; and

WHEREAS, the overall responsibility for monitoring the contract shall be under the Senior Vice President/Corporate Chief Information Officer and the Senior Vice President/Corporate Chief Medical Officer.

Now, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized 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).

Executive Summary
Proposed Contract with GSI Health

The Offices of Medical and Professional Affairs and Enterprise Information Technology Services of the New York City Health and Hospitals Corporation ("the Corporation") are proposing to enter into a contract with GSI Health ("GSI") 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 in conjunction with DSRIP including but not limited to: Health Home, Children's Health Home, NYCHHC Accountable Care Organization (ACO), and the care of the Uninsured (hereinafter referred to as the Programs).

To this end, the CCMS is a seamless, integrated platform that will enable the Corporation and its community based partners to achieve the goals of improving the health of our patients and reducing the cost of the care.

A Request for Proposal ("RFP") was issued on September 11, 2014. Eight (8) proposals were submitted and evaluated by a selection committee using criteria specified in the RFP. Four of the proposals did not meet the minimum requirements as specified in the RFP. Each of the remaining qualified vendors demonstrated their solutions for the selection committee. On the basis of its submitted proposal and system performance, GSI's proposal and system was ranked the highest overall and was deemed to be the most advantageous to the Corporation by the committee.

The contract shall be for a period of five years, with two consecutive one-year options to renew in an amount not to exceed $35,441,897 (including a contingency of $1,177,918 for additional software services as needed). The contract shall cover a population scaling up to approximately 2 million patients. The two consecutive one-year options for optional years 6 and 7 will be exercisable solely at the Corporation's discretion. These funds will be utilized to provide payment to GSI for development, support, maintenance, training, and implementation of the CCMS.

The Corporation and GSI have come to a mutual understanding of GSI's licensing fees, scope of work and time frames for completion of deliverables.

GSI will assume full responsibility for the satisfactory completion of all work performed.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Care Coordination and Management Solution

Project Title & Number: Collaborative Care Management Solution DCN # 034-0020

Project Location: 125 Worth Street, Suite 418 New York, New York 10003

Requesting Dept.: M&PA/EITS

Successful Respondent:	GSI Health
Contract Amount:	Not to exceed $35,441,897 for the entire term of seven years (including a contingency of $1,177,918 for additional software services as needed). In addition, the resolution requests authorization for the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.
Contract Term:	Five years with two (2) one year renewal options, exercisable solely by the Corporation

Number of Respondents: Eight (8)

(If Sole Source, explain in Background section)

Range of Proposals: Monthly SAAS fees ranged from $150,000 to $522,540 (based on 1M patients)

Minority Business Enterprise Invited: _X_ Yes ___ No if no, please explain: _____

Funding Source:
__ General Care ___ Capital
_X_ Grant: explain Hospital Medical Home – Year 1
_X_ Other: explain DSRIP & Health Home - Subsequent years

Method of Payment:
Time and Rate The awarded contract vendor would receive monthly payment for invoiced work.
Other: explain _____

EEO Analysis: Approved November 18, 2014
17% Minority Business Enterprise; 8% Women Business Enterprise

Compliance with HHC's McBride Principles? X Yes __ No

Vendex Clearance __ Yes __ No X Pending

(Required for contracts in the amount of $100,000 or more awarded pursuant to an RFP, NA or as a Sole Source, or $100,000 or more if awarded pursuant to an RFB.)

Background

In August 2014, NYSDOH informed HHC's Health Home division that its legacy billing program would no longer be acceptable as of Dec 31, 2014 (later postponed by NYSDOH to April 1, 2015). Because the Health Home unit's current vendor was unable to conform to the new standards, the Office of Procurement urgently issued an RFP on September 11, 2014 without prior CRC approval and without obtaining a waiver of Operating Procedure 100-5, which requires such prior approval before issuance of an RFP. On January 2, 2015, the President approved an "after the fact" deviation from only that part of the Corporation's Operating Procedure 100-5 that the Office of Procurement was unable to comply with (i.e., the requirement of obtaining prior CRC approval) given the circumstances. The RFP and selection process otherwise complied fully with Operating Procedure 100-5.

HHC intends to participate in the New York State DSRIP program, a 5-year, $6.42B waiver to promote care delivery system transformation. DSRIP is the main mechanism by which New York State will restructure the health care delivery system by reinvesting in the Medicaid program, targeting a 25% reduction in avoidable hospital admissions over 5 years.

HHC's DSRIP strategy will include multiple projects that will fall under the auspices of several programs, including but not limited to:

- PPS
- ACO
- FIDA
- Health and Home Care
- Children's Health Home
- Health Home

Despite many enhancements, the current care plan management system meets only some of the initial NYS DOH requirements for Health Home. It can neither provide the needed flexibility for the revised Health Home requirements, nor does it have the capability to serve the complex demands and needs of the above named expanding populations.

CONTRACT FACT SHEET (**continued**)

Contract Review Committee

Was the proposed contract presented at the Contract Review Committee (CRC)?

The proposed contract will be submitted at the January 7,2015 CRC meeting.

Has the proposed contract's scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC? If so, please indicate how the proposed contract differs since presentation to the CRC:

There are no changes to the contract's scope of work, timetable, budget, and contract deliverables.

Selection Process

Chairperson

Lauren Johnston	Office of Patient Centered Care

Members

Ann Frisch	Health and Home Care
Bob Moon	Behavioral Health
Dave Cohen	IT
Deborah Rose	Health Home
Jared Sender	IT
Jennella Joseph	Revenue Management
Maria Arias-Clarke	Finance, Non-voting member
Megan Cunningham	ACO
Paul Albertson	Supply Chain Services
Shelley Cao	DSRIP

List of Firms Responding to the RFP:

1. ACUPERA
2. ADVISORY BOARD COMPANY- CRIMSON
3. BTQ
4. CARADIGM
5. e-CLINICAL WORKS
6. GSI HEALTH
7. NETSMART
8. PHYCARE SOLUTIONS

List of Firms Evaluated:

- THE ADVISORY BOARD COMPANY- CRIMSON
- CARADIGM
- GSI HEALTH
- NETSMART

Firm Selected:

- GSI HEALTH

Describe the process used to select the proposed contractor, the selection criteria, and the justification for the selection:

As a first step in evaluation, proposers provided two current clients for whom they provide a functional Care Coordination and Management Solution ("CCMS") that meets all of the Jan 2014 New York State Health Home Requirements. Only proposers who were able to provide this list were considered by the selection committee in the succeeding evaluation.

A. **Minimum Qualification Criteria ("MQC")** Pass/Fail – Proposals submitted before the September 19, 2014 deadline were reviewed by the Committee based on the Pass/Fail criterion. The Committee made this determination based on a combination of the proposer's MQC response document which included reference calls to the proposer's current lead Health Home client(s).

B. **Preliminary Evaluation** – Only proposals that met the Minimum Qualification Criteria were reviewed by the Committee using the scoring sheet outlined in Section III. The following weighting formula was applied to determine a score for qualified proposals:

1. Care Coordination and Care Management Requirements – 50%
2. Specific Health Home Requirements– 15%
3. Technical Requirements – 15%
4. Billing as a Service – 15%
5. Training and Implementation Plan – 5%

C. Live Presentations – The Committee invited up to the top 4 scoring proposers to provide a 1 hour live presentation (including time for questions) to the committee. Presentations were scheduled between September 29 and October 2, 2014.

D. **Secondary Evaluation** – The Committee then re-scored the live presenters and determined the top 2 proposers (The Advisory Board/Crimson and GSI Health) based on the following weighting formula.

1. Care Coordination and Care Management Requirements – 50%
2. Specific Health Home Requirements– 10%
3. Technical Requirements – 15%
4. Billing as a Service – 10%
5. Training and Implementation Plan – 5%
6. Reference Calls – 10%

E. Negotiations – The Committee and the Procurement team discussed cost, scope, etc. with the top 2 proposers, The Advisory Board/Crimson and GSI Health.

Selection criteria:

F. Final Evaluation – The Committee determined the winner of the RFP based on the following formula:

1. Score from Secondary Evaluation – 50%
2. Total Cost – 50%

The CCMS Evaluation Committee decided to revisit the final scoring for Crimson and GSI for the following reasons:

1- During the course of our referral calls with existing clients of our two vendor finalists, there were some negative comments regarding many essential functions of Crimson. These included references to: promised but undelivered functionality such as reporting; significant performance issues (slow application response times) which users referred to as "the black wheel of death"; an unfamiliarity with upcoming NY State Health Home workflows, specifically around Children's Health Home; inexperience with EMR interfaces; and data ingestion problems.

2- The existing RHIO/HIE landscape has changed in the last two weeks. NYeC, who formerly was charged with providing technical resources and support to the downstate RHIOs, has restructured and will no longer be providing those services in order to focus

on its own HISP and the implementation of the SHIN-NY, the Statewide Health Information Network for New York. This potentially puts some of these RHIOs, who were dependent on NYeC resources, at risk. HIE functionality is a major aspect of DSRIP and if RHIOs become unavailable at any time during the 5 year DSRIP period, this would put HHC in a difficult situation. Because the CCMS platform would be receiving most if not all of the same data as the RHIO, the committee has decided to score the vendors with an additional focus as to its suitability for use as a backup HIE platform.

Justification of selection:

- **Robust Care Coordination and Care Management Platform**
  - Facilitates patient care plan development, team collaboration, real-time alerting, documentation and reporting
  - Enhanced risk stratification and analytics capability
- **Knowledge of New York State Programs and Technology Systems**
  - Locally based and well connected to State healthcare administrators
  - Ability to anticipate and respond quickly to evolving regulatory landscape
- **Ease of Integration with Health Home and PPS Partners**
  - Critical mass of NYC Lead Health Homes and downstream providers utilize GSI
  - Reduces training, implementation, and coordination burden
- **Core Technical and HIE Functionality**
  - Meets “Dial Tone Service” requirements
  - Potential alternative for health information exchange if RHIO implementation is delayed
- **Reference Recommendations**
  - Highly positive reviews as compared to competitors, particularly with regard to Health Home support

Other Positives in GSI's Favor

- Has experience in the New York City Health Home ecosystem. Has understanding of connectivity with RHIOs and EMRs.
- Is already a provider for many downstate Health Homes and potential DSRIP PPS partners. This can simplify and speed connectivity with other Health Homes.
- Can support Health Home out of the box.
- Has equivalent Data Center to other vendors.
- Has insight into NY State policy. This will help GSI to anticipate, respond and react to new state technical and reporting requirements before other vendors are aware of changes.
- Supports Direct protocol for secure email. This is a requirement of Meaningful Use.
- Supports CCD clinical data transport. This is also a requirement for Meaningful Use.
- Has out of the box reporting functionality including critical FACT GP and CMART for Health Home.
- Will have risk stratification tool available 1st/2nd Quarter 2015.
- Has a Master Patient Index algorithm that will address patient matching until an Enterprise level solution is available.
- Alerting is available out of the box.

Negatives of Other Bidders

- Crimson: Negative reference call. It was reported that many promised functions are not available and that there are frequent performance issues. Does not support CCD or Direct secure email. Would require some customization.
- Caradigm: Did not display any expertise or knowledge of Health Home or other aspects of Care Plan Management or Care Coordination. CCMS would need to be custom built on their platform by a company that has been late with many deliverables for HHC in the past.
- Netsmart: Did not have many of the necessary features such as Direct secure email, Lab interfaces, document uploads and alerting. Would require significant customization.

The selected vendor is expected to immediately provide an off-the-shelf solution to meet these Health Home detailed requirements, and to go "live" following a 90 day implementation process. As the specifications for the impending Children's Health Home and DSRIP get released, the selected vendor will commit to jointly agreed-to implementation dates, which will also include the Uninsured. The ACO implementation date is flexible, based on the release details/dates for Children's Health Home and DSRIP.

Provide a brief costs/benefits analysis of the services to be purchased.

IT Build	$ 12,957,097
Program Configuration and Deployment	$ 1,087,200
PMPM	$ 21,159,600
Training	$ 238,000

Provide a brief summary of historical expenditure(s) for this service, if applicable.

The initial contract for a care plan management system totaled $16.1 million for 7 years (5 years and 2 - one year renewals), plus work orders for all work deemed outside the initial statement of work ($830,014 to date). Currently, EITS is paying an annual maintenance fee ($428,000). Spending will continue for the remainder of the contract by EITS to support the Patient Portal and to achieve Meaningful Use certification.

Provide a brief summary as to why the work or services cannot be performed by the Corporation's staff.

HHC's existing technology does not meet, and is not scalable to the requirements needed for operating and supporting the Health Home, ACO, DSRIP programs.

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

It is not anticipated that the contract will produce artistic/creative/intellectual property.

Contract monitoring (include which Senior Vice President is responsible):

- Ross Wilson, MD, SVP, Corporate Chief Medical Officer – M&PA
- Bert Robles, SVP, Chief Information Officer – EITS
- Lauren Johnston, Senior AVP, Chief Nurse Executive – M&PA
- Paul Contino, Chief Technology Officer – EITS
- Jared Sender, Population Health Management Lead – EITS
- David Cohen, IT Program Manager – EITS
- Inger Dobson Slade, Associate Director – M&PA

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

As part of its efforts, the selection committee posted this RFP in The City Record, a long established outreach practice in maximizing inclusive responses to same. Further, it is noted that the selected candidate, GSI Health, has a woman as its principal. Lastly, if approved, GSI Health will be required to submit proof of New York State certification for all subcontractors.

Received By E.E.O. September 16, 2014
Date

Analysis Completed By E.E.O. *November* 18, 2014
Date

Manassas C. Williams, AVP
Name

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

160 Water Street, 13th Floor, New York, NY 10038 Tel: 212-788-3380 Fax: 212-788-3689

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: Inger A. Dobson Slade, MPA, PMP
Project Director, HIE Initiatives
Central Office – Office of Patient Centered Care

FROM: Manasses C. Williams

DATE: November 18, 2014

SUBJECT: EEO CONTRACT COMPLIANCE

The proposed contractor/consultant GSI Health, LLC, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.
This company is a:
[X] Minority Business Enterprise [ ] Woman Business Enterprise [ ] Non-M/WBE

Project Location(s): Office of Patient Centered Care

Contract Number: _____

Project: Implementation of Care Coordination and Management Solutions

Submitted by: Office of Patient Centered Care

EEO STATUS:

1. [x] Approved

2. [ ] Conditionally approved with follow-up review and monitoring-No EEO Committee Review

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

c:

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

MPA/IT Committee

Request for Authorization to contract with GSI Health, Inc.

January 15, 2015

Lauren Johnston, Sr. AVP and Chief Nursing Officer
Paul Contino, Chief Technology Officer

Action Requested

- HHC is seeking Board approval to enter into contract with GSI Health, Inc. for a Care Coordination and Management Solution with a Not-To-Exceed Cap of $35,441,897 (5 year term with 2-one year options)

Care Coordination and Management Solution

The need for a CCMS can be summarized in two reasons: **Urgent** and **Transformational**

Urgent – The current Health Home billing process will become obsolete on April 1, 2015 (previously December 31, 2014) and HHC's current care coordination platform is unable to assimilate the data to produce a bill.

Transformational – HHC needs a singular platform to support the care coordination of up to 2 million patients as Health Home expands (growth up to 5K patients, rev. of $15 mm per year) and DSRIP continues to unfold.

Care Coordination and Management Solution

The corporation expects to manage at least 250,000 and as many as 2 million new and current patients through the CCMS. Patients may be enrolled in one or more of The Programs that support HHC's integrated healthcare delivery transformation strategy.

Procurement Methodology

- Request for Proposal process was utilized
- Advertisement posted in the City Record
- Eight (8) vendors were invited or expressed interest in submitting proposals
- 4 vendors met the minimum qualifications and presented verbal presentations: Caradigm, Crimson, GSI Health, NetSmart
- Evaluation committee:
  - **Lauren Johnston, Chair**
  - **Jared Sender - IT**
  - **Ann Frisch - Health and Home Care**
  - **Jennella Joseph – Revenue Management**
  - **Bob Moon - Behavioral Health**
  - **Maria Arias-Clarke - Finance**
  - **Dave Cohen - IT**
  - **Megan Cunningham – ACO**
  - **Deborah Rose – Health Home**
  - **Paul Albertson – Supply Chain Services**
  - **Shelley Cao - DSRIP**

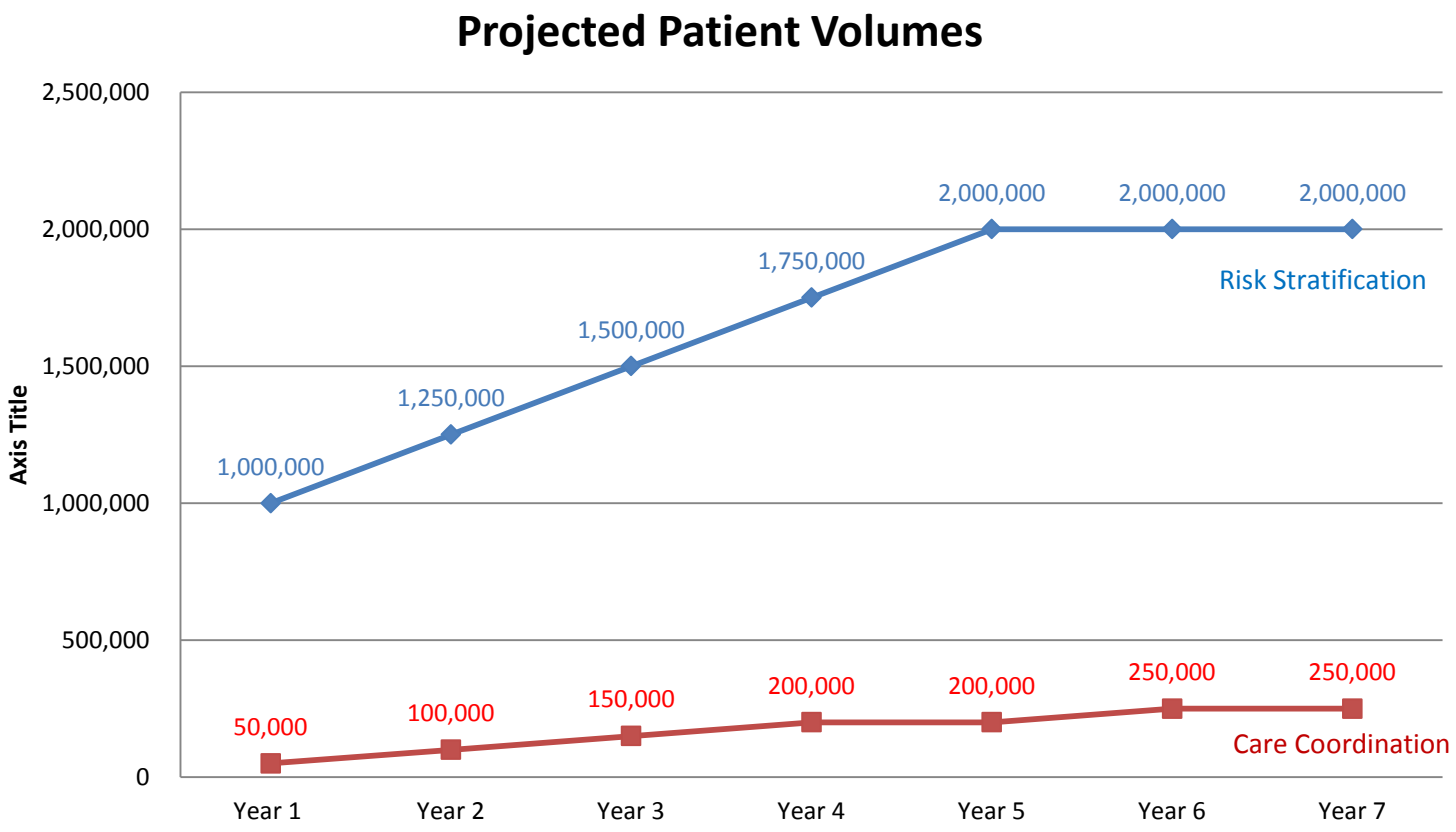
9/11/2014 RFP Published to NYC Records → 9/26/2014 RFP Close Date → 9/29/2014 Minimum Qualification Criteria Selection → 9/30/2014 1st Round of Selection → 10/6/2014 2nd Round of Selection → 10/17/2014 Selection of GSI → 12/15/2015 Final Negotiations with GSI

GSI Health Inc. – The Unanimous Choice

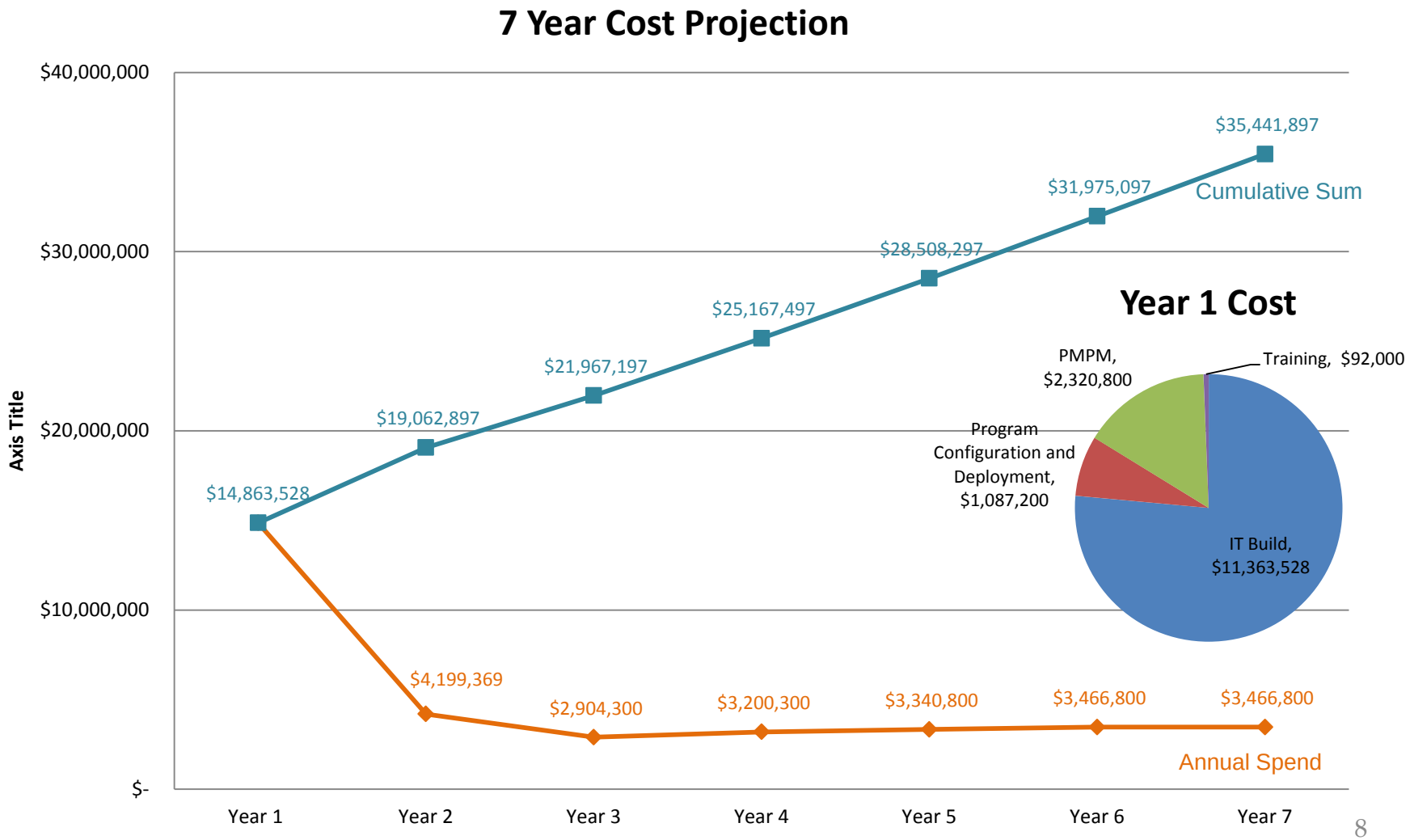
This Care Coordination and Management Solution will serve as the foundational population health management, coordination, communication, collaboration, documentation tracking, and registration system for HHC's overall Delivery System Reform Incentive Payment (DSRIP) strategy and several programs in conjunction with DSRIP including: Health Home, Children's Health Home, HHC's Accountable Care Organization (ACO), Performing Provider Systems (PPS's) and the care of the Uninsured.

- Meets our Minimum Qualification Criterion - a functional CCMS that meets all of the Jan 2014 New York State Health Home Requirements
- Currently the platform used in 10 NYS Health Homes
- Maimonides PPS has identified GSI as its technology solution for its DSRIP application
- Propose a 60-90 day roll out for immediate use by the Health Home

Growth Projections



Total Cost of Ownership



Resolution

- 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).

Medical &Professional Affairs/IT Committee to the Board
e-Prescribing Initiative and Meaningful Use Update

Thursday, January 15, 2015

1. e-Prescribing Initiative Update:

I would like to update 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.

2. 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.

Enterprise e-Prescribing (eRx) Initiative and Meaningful Use (MU) Updates
Medical and Professional Affairs/IT Committee

Maricar Barrameda

January 15, 2015

e-Prescribing Initiative

E-Prescribing Overview

According to Bureau of Narcotics Enforcement (BNE), NY issued ~1.4B forge-proof official prescription forms to all registered practitioners within the State from 2006-2013 at a cost of $78.7M.

- On June 11, 2010, Federal Drug Enforcement Administration rule allow electronic prescribing of controlled substances.

- On June 11 2012, New York State Legislature passed the Internet System for Tracking Over-Prescribing (I-STOP) Act due to the recent increase of prescription drug abuse. A major focus of the I-STOP Act is the creation of a “real time” Prescription Monitoring Program Registry which is aimed at shrinking the number of fraudulent prescriptions, minimizing doctor-shopping and reducing the over-prescribing of controlled substances.

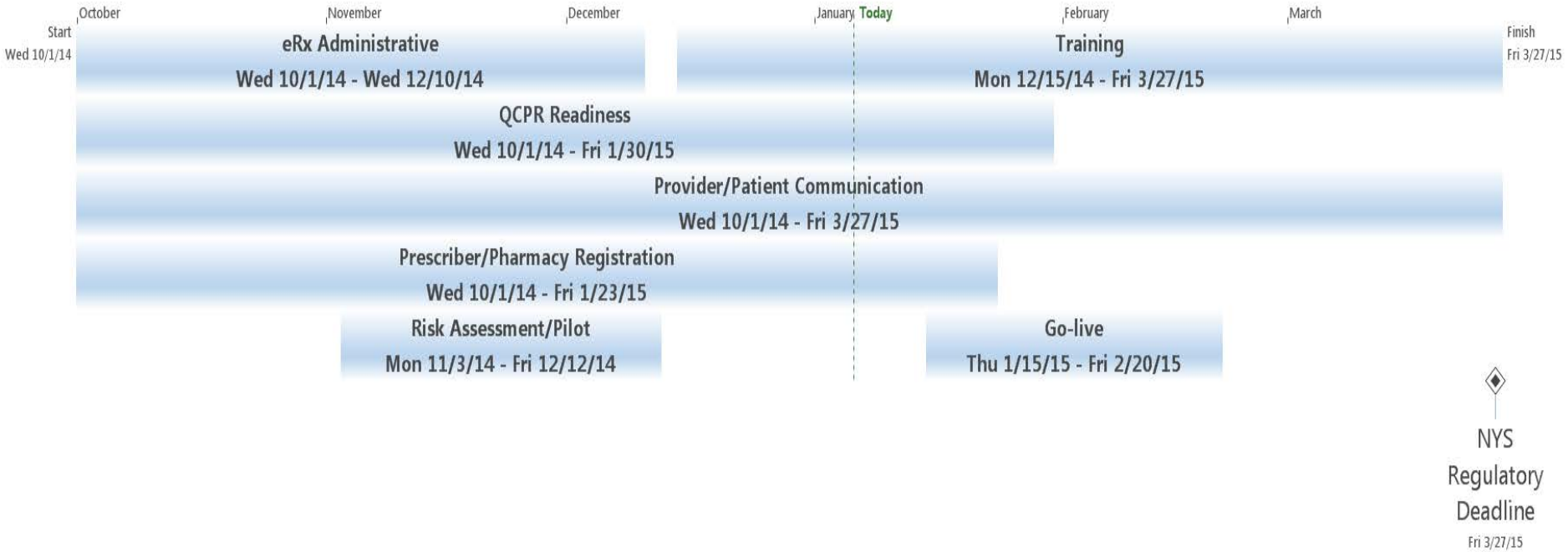
- On March 27, 2013, NYS Regulations allow for electronic prescribing of controlled substances (EPCS).

Effective March 27, 2015, I-STOP mandates all prescriptions issued in the state of New York be done electronically.

NY State passed the legislation designed to more effectively curtail forged and counterfeit prescriptions, track patterns of potential prescription misuse and improve patient safety.

Timeline

HHC's prescribers must meet e-prescribing deadline by March 27, 2015. In December, 2014, an awareness campaign was initiated enterprise-wide. Training has started and will continue as needed. The implementation is scheduled between Jan15 thru Feb 20, 2015.



Risks and challenges are being addressed and monitored closely to stay on schedule. They are shared and discussed with the Steering Committee and its members for review and resolution.

- Transforming the prescribers workflows may impact clinical operations.
- Substantial amount of patient education and awareness on the adoption of the new process a considerable challenge.
- A subset of systems related to e-prescribing still pursuing to implement its certified product.
- Electronic Prescribing of Controlled Substances (EPCS) registration requiring the prescribers' participation. Fewer than 5% have registered so far. No one else could do this on their behalf.
- Staggering number of prescribers in twenty-one (21) facilities impacts capacity for user training and support.

MEANINGFUL USE

CMS EHR Incentive Program System: Eligible Hospitals

Meaningful Use Stage 1 Yr1 &2 – Audits

- Nine (9) facilities were audited by the Centers for Medicaid and Medicare Services (CMS) and passed.
- One (1) facility was audited by the New York State Office of the Medicaid Inspector General with pending status.
- Eleven (11) facilities were audited by Health & Human Services Office of Inspector General with pending status.

Meaningful Use Stage 2 Yr1 - Incentive Dollars

- Medicare = $8,041,056.03
  - As of 12/26/2014, HHC received Medicare Meaningful Use 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 was moved back until January 31, 2015.

Meaningful Use Stage 2 Yr2 – ongoing and compliance closely being monitored

Meaningful Use Stage 3 – Proposed rule is expected sometime this winter

- The Office of Management and Budget (OMB) received the proposed rule for Stage 3 of the meaningful use program.
- OMB review is one of the last steps before rules are published in the *Federal Register*
- The proposed rule for Stage 3 focuses on improving health outcomes and furthering interoperability.

CMS EHR Incentive Program System: Eligible Professionals

Basic Information for Eligible Professionals Participating in the Medicaid EHR Incentive Program:

- The program is administered voluntarily by states and territories, and will pay incentives through 2021.
- Eligible professionals can participate for 6 years, and participation years do not have to be consecutive.
- The last year that an eligible professional can begin participation is 2016.
- Incentive payments for eligible professionals are higher under the Medicaid EHR Incentive Payments— up to $63,750 over 6 years.

Eligible professionals can receive an incentive payment for adopting, implementing, or upgrading, certified EHR technology in their first year of participation.

Source: CMS

CMS EHR Incentive Program System: Eligible Professionals

Eligible Professionals (EP) requirements:

- Fully enrolled in Medicaid *(not eligible if enrolled only as an ordering provider)*
- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse Practitioners
- Certified Nurse-Midwives
- Dentists
- Physician Assistants (who provide services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant)

Qualification for participation *($63,750 incentive dollars per EP)*

- an EP must meet a minimum 30% Medicaid patient volume. *(Pediatricians must meet a minimum 20%)*
- EP cannot be hospital based with ≥ 90% services furnished in inpatient or emergency room

of Eligible Professionals at HHC

- Calculation of HHC eligible professionals' patient volume and percentages is in progress

Timeline

- AIU (Adopt, Implement, Upgrade) attestation plan by March 2015 to receive first payment of $21,250 per EP
- Installation of QCPR beta code on January 16th
- Go Live for Beta Site *(Harlem Hospital)* on May 2015
- Other facilities to follow within two to four weeks thereafter

Questions and Answers