NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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125 Worth Street ▪ New York, NY ▪ 10013

BOARD OF DIRECTORS MEETING
THURSDAY, JANUARY 30, 2014
A~G~E~N~D~A

Call to Order - 4 pm	Dr. Stocker
1. Adoption of Minutes: December 19, 2013	
Chairman's Report	Dr. Stocker
President's Report	Mr. Aviles
Executive Session	
>>Action Items<<	
Corporate	
2. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to enter into a contract with EMC Corporation for VMWare Virtualization software through a NYS Office of General Services contract in an amount not to exceed $4,178,395 which includes a 15% contingency of $545,007 over a three year term. *(Med & Professional Affairs/IT Committee – 01/09/2014)*	Dr. Stocker
3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to procure and outfit seventy (70) ambulances in Fiscal Year 2014 on behalf of the Fire Department of the City of New York through City-wide Requirements Contracts for a total amount not to exceed $20.5 million. *(Capital Committee – 01/09/2014)*	Ms. Youssouf
Committee Reports	
➢Capital	Ms. Youssouf
➢Equal Employment Opportunity	Rev. Lacey
➢Finance	Mr. Rosen
➢Medical & Professional Affairs / Information Technology	Dr. Stocker
➢Strategic Planning	Mrs. Bolus
Subsidiary Board Report	
➢ HHC Insurance Company/Physicians Group	Mr. Aviles
Facility Governing Body / Executive Session	
➢Kings County Hospital Center	
➢Dr. Susan Smith McKinney Nursing and Rehabilitation Center	
Semi-Annual Report (Written Submission Only)	
➢Elmhurst Hospital Center	
>>Old Business<<	
>>New Business<<	
Adjournment	Dr. Stocker

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 19th of December 2013 at 4:00 P.M. pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Dr. Michael A. Stocker
Mr. Alan D. Aviles
Josephine Bolus, R.N.
Dr. Jo Ivey Boufford
Dr. Vincent Calamia
Dr. Herbert F. Gretz, III
Dr. Adam Karpati
Ms. Anna Kril
Mr. Robert F. Nolan
Mr. Bernard Rosen
Ms. Emily A. Youssouf

Andrea Cohen was in attendance representing Deputy Mayor Linda Gibbs, Dr. Amanda Parsons was in attendance representing Commissioner Thomas A. Farley, and Linda Hacker was in attendance representing Commissioner Robert Doar, each in a voting capacity. Dr. Stocker chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on November 21, 2013 were presented to the Board. Then, on

motion made by Dr. Stocker and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on November 21, 2013, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

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

On behalf of the Board, Dr. Stocker and Mrs. Bolus complimented and thanked the staff at HHC for their consistent professional support provided to the Board throughout the year, particularly the staff in the Board Office and transportation unit.

Dr. Stocker received the Board's approval to appoint Dr. Gretz to serve as Chairman of the Quality Assurance Committee.

PRESIDENT'S REPORT

Mr. Aviles' remarks were in the Board package and made available on HHC's internet site. A copy is attached hereto and incorporated by reference.

ACTION ITEMS

RESOLUTION

2. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract with **Hawkins Delafield & Wood, LLP** to provide **bond counsel services** related to the structuring and continuing implementation of the Corporation's financing program for the period beginning December 1, 2013 through November 30, 2016, plus two one-year

renewal options solely exercisable by the Corporation. The hourly rates are: $420 for Partners, $360 for Senior Associates, $280 for Associates, $210 for Junior Associates and $150 for paraprofessionals.

Mr. Rosen moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

3. Authorizing the President of the New York City Health and Hospitals Corporation to enter into a contract to purchase software, hardware, services and corresponding **maintenance for a biomedical middleware software solution** with **iSirona, LLC,** through a Federal General Services Administration ("GSA") contract in an amount not to exceed $6,454,161, which includes a 10% contingency of $586,742 for a one year term with four one-year options to renew at the Corporation's exclusive option.

Bert Robles, Senior Vice President and Chief Information Officer, presented an overview to the Board of the role the vendor will play in creating an integration solution that will enable the Corporation to connect biomed equipment, current and future, seamlessly into the electronic medical record.

Dr. Stocker moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

4. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute contracts with various authorized resellers on an on-going basis over a one Year period for **the purchase of Cisco networking equipment and software** through NYS Office of General Services ("OGS") contracts in an amount not to exceed $4,188,853, which includes a 20% contingency.

Dr. Stocker moved the adoption of the resolution, which was duly seconded and unanimously adopted by the Board.

RESOLUTION

5. Authorizing the President of the New York City Health and Hospitals Corporation **to purchase** from **Dyntek Services, Inc.** through a NYS Office of General Services contract **F5 Load Balancers hardware, software and services** in an amount not to exceed $4,448,182, which includes a 15% contingency of $580,198.

Dr. Stocker moved the adoption of the resolution, which was duly seconded and unanimously adopted by the Board.

RESOLUTION

6. Authorizing the President of the New York City Health and Hospitals Corporation and **CareFusion Solutions, LLC,** to provide automated dispensing systems used in the supply chain process for medication and supplies. The proposed contract, an enhanced Premier contract PPPH14CFS, would standardize the cost, support, services and at the same time set an end date for all current active contracts. Currently we spend $23,921,500 on automated medication dispensing systems and we need $4,848,048 in upgrades and additional fees. By doing a single overall contract rather than multiple smaller contracts, the Corporation would save $5,458,240 over the term of the contract or $1,091,648 annually. The five (5) year contract cost is $24,447,347 for existing equipment and 73 new rental units. A Contingency of 20% ($4,889,470) has been included to provide expansion opportunities for a total not to exceed amount of $29,336,817.

Dr. Stocker moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

7. Authorizing the President of the New York City Health and Hospitals Corporation to execute a three-year revocable **license agreement** with **Simon and Company** for continued use and occupancy of approximately 144 square feet of space including use of the reception area, conference room, library, storage area, kitchen, high-speed internet service and digital cable television at an occupancy fee rate of $1,494 per month or approximately $17,962 per year at 1660 L Street, NW, Washington, DC, for use the the **Corporation's federal lobbyist.**

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

RESOLUTION

8. Authorizing the President of the New York City Health and Hospitals Corporation to execute a five-year **lease agreement** with **Franciosa Owners, LLC** for 5,300 square feet of space at **1012 East Gun Hill Road, Borough of the Bronx**, to house the Gun Hill Health Center, operated by **Jacobi Medical Center** at an initial rent of $29.78 per square foot to increase at 2.5% per year with the Corporation responsible for the payment of real estate taxes, water and sewer rents, and separately metered electricity provided that the Landlord shall perform renovation work which includes exterior storefront replacement, painting, and the installation of two new rooftop HVAC units and installation of a new water heater.

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

RESOLUTIONS

9. **Approving Tamira Boynes** for nomination to serve as a member of the **Board of Directors of MetroPlus Health Plan, Inc.**, to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

Mr. Rosen moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

- AND -

10. **Approving Meryl Weinberg** for nomination to serve as a member of the **Board of Directors of MetroPlus Health Plan, Inc.**, to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

Mr. Rosen moved the adoption of the resolutions which were duly seconded and unanimously adopted by the Board.

RESOLUTIONS

11. **Approving and ratifying** the actions of the **HHC ACO Inc. Board of Directors** to fix the number of Directors of the HHC ACO Inc. Board of Directors at nine, subject to approval by the Centers for Medicare and Medicaid Services (CMS) of the Participation Agreement executed between the ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI doing business as Mount Sinai Elmhurst Faculty Practice Group ("Elmhurst FPP") and HHC ACO Inc., which CMS approval has since been granted; **AND** approving and ratifying the actions of the HHC ACO Inc. Board of Directors, subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified: A Director to be named by the HHC ACO Inc. by the Elmhurst FPP, as specified in a writing by the Elmhurst FPP, as specified in writing by the Elmhurst FPP that is delivered to the Chairman of HHC ACO Inc; **AND** approving and ratifying the actions of the HHC ACO Inc. Board of Directors that the existing non-HHC Participants Director of the HHC ACO Inc. Board of Directors shall hereafter be named pursuant to a designation by a majority in number of HHC ACO Inc.'s ACO Participants, as defined in 42 C.F.R Part 425, other than the Corporation and the Elmhurst FPP, that have executed Participation Agreements with HHC ACO Inc., which Director is specified in a writing signed by such majority that is delivered to the Chairman of HHC ACO Inc.

- AND -

12. Authorizing that each of the **following persons be elected to serve as a Director of the HHC ACO Inc. Board of Directors,** subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified: Alan D. Aviles, Antonio D. Martin, Salvatore J. Russo, Ross M. Wilson, M.D., Marlene Zurack, Jeroman Berger-Gaskin, a Medicare beneficiary Director, a Director who shall be the Chief Executive Officer of Physician Affiliate Group of New York, P.C. ("PAGNY"), a Director to be named by the ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI doing business as Mount Sinai Elmhurst Faculty Practice Group, as specified in a writing by the Elmhurst FPP that is delivered to the Chairman of HHC ACO Inc., and, a Director to be named pursuant to a designation by a majority in number of HHC ACO Inc.'s ACO Participants, as defined in 42 C.F.R. Part 425, other than the Corporation and the Elmhurst FPP, that have executed Participation Agreements with HHC ACO Inc., which Director is specified in a writing

signed by such majority that is delivered to the Chairman of HHC ACO Inc.

Salvatore Russo explained that HHC is the sole member of the ACO and as such, many rights are reserved to HHC so that certain acts of the ACO Board need to be ratified by the HHC Board. Dr. Stocker stated that he believes that there are adequate protections so that HHC will not lose control over the entity.

Dr. Parsons and Dr. Boufford expressed concern that public health be represented on the ACO Board. After substantial discussion, the HHC Board agreed to vote on the resolutions as presented, with the understanding that the ACO Board would be asked to review its board structure in order to have effective public health representation and to come up with a recommendation within the next 90 days as to how that can be achieved.

Mr. Aviles moved the adoption of the resolutions which were duly seconded and unanimously adopted by the Board.

BOARD COMMITTEE AND SUBSIDIARY BOARD REPORTS

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

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Stocker reported that the Board of Directors as the governing body of Bellevue Hospital Center reviewed, discussed and adopted the facility's report presented; and reviewed and accepted the semi-annual written reports for Jacobi Medical Center and North Central Bronx Hospital.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:18 P.M.

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

COMMITTEE REPORTS

Audit Committee – December 10, 2013
As reported by Ms. Emily Youssouf

The first action item on the agenda, the KPMG Management Letter, was presented by: Jim Martel, Engagement Partner; Camille Fremont, Senior Manager and Maria Tiso, Account Executive.

Mr. Martell stated that the Management Letter is a criticism letter, observations in terms of issues relating to internal control. He outlined the different levels of the Management Letter: one being more operational in nature, such as the one you received, and one is called the material weakness and/or significant deficiencies. The good news is that HHC has not receive either one of these types of letters -- ours is a letter of observations which would give us concern as it relates to the overall preparation of the financial statements. The comments that you have embodied in this Management Letter are recommendations to improve internal controls and Ms. Fremont will walk you through some of the comments. The Management Letter is broken up into several sections, one is current year comments, but more importantly, there is an industry issue comment which is more important to the Audit Committee because that is where the industry is going.

Ms. Fremont began the presentation by stating that on page two is the matrix of observations, it lists which networks and facilities they went to for their site visits and any comments they had. Ms. Fremont said that the first area they looked at is the affiliations and there continues to be contracts that are executed after the beginning of the contract period as well as certain recalculation documents that were not prepared on a timely basis. KPMG continues to recommend that management continue to work with affiliates to ensure that all contracts are signed prior to the commencement of the contract period and those recalculation documents are done timely.

Ms. Fremont continued and said that the next area within the Management Letter pertains to Construction Management. During the current year, KPMG realized that the construction in progress balance at year end did not include approximately $16 million related to the major modernization project at the Henry J. Carter Center. KPMG recommends that management ensure that they have all facts, including the construction in progress balance so that the balance is accurate at year end.

Ms. Fremont then said that last area she will briefly speak on is materials management. They noted that purchased items are received at the departmental level, so there is no centralized receiving department. They noticed in some situations that the individual who ordered the goods was also the individual receiving the goods so there is a lack of segregation of duties. KPMG recommends that management create a process as to ensure that there is some sort of segregation of duties between who orders the goods and who ultimately receives it.

Ms. Youssouf commented that regarding Construction Management, the Capital Committee has worked hard with staff to try to make significant changes in that process and she thinks that we are well underway to do that.

Ms. Fremont commented that the comment they are bringing to your attention is more of a reconciliation issue between all the books and records to ensure communication among all departments. Then Ms. Fremont said that she will turn over the letter to Mr. Martell so he can discuss some of the industry observations.

Mr. Martell stated that industry issues are issues that are affecting the not-for-profit world and the healthcare institutions. Healthcare transformation, there are a lot issues going on as it relates to day-to-day operations, new organizations and new contracts. HHC could be a winner or could be a loser, but the evaluation is you got to be able to look at it half full, half empty and so forth. The biggest issue as it relates to transformation is that this is not stopping. Just because the changes came in this past September, October, there are constantly ongoing changes and the organization needs to retool itself on an ongoing basis. Physician integration, joint venturing – the organization has done a lot of changes over the past years with PAGNY – you are reacting to the requirements of the physicians groups. Here in the Northeast we tend to be a little slower in terms of competitiveness and in terms of doing joint venturing, but obviously the corporation is dealing with things such as the lab at North Shore. Again this is more in terms of what your competitors are doing to grow their bottom line, grow their revenue stream. Even though it may not be something that is your competency, you know very well that your competitors are trying to make it their core competency. Mr. Martell thinks that the joint venturing aspect is extremely important.

Ms. Youssouf asked if there are any areas in joint venturing that he thinks HHC should look at, she knows that the senior staff is spending an enormous amount of time doing that, but is there anything that really pops out from the competitors. To which Mr. Martell responded that the only thing that the competitors have a little more leeway in the way of governing structure is versus being a hospital sponsored by the City so you have to deal with that. A lot of these competitors are doing outsourcing, joint venturing with security, housekeeping, but they are also doing other things with outsourcing. For example, their CBO, their PHI filing, their building system and some of them are looking at outsourcing the entire financial management responsibility that will do all the billing on behalf of the organization. The key thing with HHC is the revenue stream which is Medicaid and Medicare, and the managed care organization of MetroPlus which gives HHC an opportunity to deal with other organizations. There are things for HHC to maneuver within the transformation and changes, but at the same time you just got to be aware of it. So the short answer is he has not looked at in terms of what HHC is not doing. What HHC is doing under the restrictions is, by far, as much at this point in time.

Mr. Martell continued by stating that ICD-10 is coming, management has hired consultants. It is there, it is going to be live and it is going to be problem. It is an issue that will culminate next year, and hopefully there will be enough coders around to help all of us in the healthcare industry. The Privacy Corporate Compliance program has really taken on a lot of the issues relating to the entire world associated with not only privacy but all compliance issues unto itself. Again these are the things that your colleagues are dealing with in the top 10 of the audit committee boardrooms.

Mr. Martell then continued with cloud computing – it is becoming more and more prevalent, it is here. It is eliminating data store warehouses. Every technology company is advertising that they have the ability to store all the information for you and have it secured. The cloud computing is something that is very, very prevalent going on outside of New York and also inside of New York.

Ms. Marlene Zurack, Senior Vice President, Finance, asked Mr. Ramlakhan to approach the table. He introduced himself as Enrick Ramlakhan, Assistant Vice President of Business Applications. He stated that this is something they are looking at and have to tread carefully. We have to make sure the advantages and disadvantages are there, also we need to ensure that the costs are also controlled, because when you go to Cloud a lot of services we take for granted are no longer provided. We are going to get there; it is a matter of how safe we will be.

Ms. Youssouf asked if cloud computing is going to replace or is it in addition. Mr. Ramlakhan responded that it would be in addition to, and ultimately, maybe 10 years from now it may replace.

Committee Member, Mrs. Josephine Bolus asked how you will be able to conform to that. To which Mr. Ramlakhan answered that there are various methods we have to evaluate and testing safeguards are in place. It is up to us, as the custodians of that data to ensure that whoever we put in charge of it, that it is always encrypted and it is safe.

Mr. Youssouf asked if there is a large system that is currently totally converted to Cloud. Mr. Martell answered no, not yet.

Ms. Tiso added that a lot of the systems are years away of implementing Cloud. A lot of them started eliminating some of the data storage warehouses and she thinks that when you put all the information on the file tapes most of that information is being transported to the Cloud now instead of the data centers.

Mr. Ramlakhan added that when we look at some applications, we do look at some Cloud based organizations. We call it software as a service – we have application service product. We do not house all – we have some of it here on-site and we have to have that ability to have certain sensitive data, obviously restore it to backup. It is not something we can wait until the next day to get backup, downtime has to be as minimal as possible.

Mr. Martell then continued with the last two comments – the SEC (Securities Exchange Commission) and the healthcare agency metrix. Obviously HHC has issued debt and whether it is debt of their own or debt through the City, there are certain financial reporting requirements. HHC does provide quarterly or semiannually reports that are given to the filing centers, but the biggest issue at least with the SEC is that there will be and there is just starting to be reviews performed by them where in the past there were never or limited. As you go forward, the cost of bonds are actually traded, and when you trade bonds, it is just like having stock, you have the public purchasing and selling these particular instruments. There are requirements that the SEC is now going to start implementing over the not-for-profits and oversight associated with that. We have seen the SEC get involved with several not-for-profits over the past year relating to questions and concerns relating to the financial statements. As you move forward, it may not be today or tomorrow, maybe three years or four years down the road, there will be more oversight as relates to quarterly filing and annual filings associated with the SEC.

Ms. Youssouf asked if he was referring to continuing disclosure. Mr. Martell answered yes, since there are quarterly filings, that becomes public information and people perhaps purchase or sell the bonds based on this information.

Ms. Youssouf asked if that was one of the problems Detroit, and the State of Illinois had. Mr. Martell said absolutely and Miami.

Ms. Zurack stated that the Finance Committee is submitted the quarterly financials, and what we do is an excerpt on a document that we have disclosed to the market for as long as she has been at HHC which is 13 years.

Ms. Youssouf asked what it is called. To which Mr. Martell responded post it, and then anybody has access to it.

Ms. Zurack added that years ago we used to have to mail a significant amount of our bonds and it is posted to EMMA (Electronic Municipal Market Access) as of maybe 5 years ago.

Ms. Youssouf asked if there is anything pending with the SEC that we should especially keep our eyes on? To which Mr. Martell answered that the SEC has not come out and formally had reviews or audit work plans, but he does believe that the municipal markets are going to become more stringent.

Then Mr. Martell jumped to the final comment – the metrics. There is this whole issue of a public entity versus a private entity and a private entity could be a non-SEC company that issues stock. Most people think that not-for-profits are private entities, but the accounting guidance

has come out and said if you have conduit debt, which HHC has conduit debt, it is issued through DASNY (Dormitory Authority of the State of NY) it is considered a public entity.

Ms. Zurack said that some say North Shore and LIJ are now public. Mr. Martell stated that all these organizations have conduit debt which raises the bar in terms of what is expected and once again added that what is going on within other boardrooms and other committee meetings are important to this committee. It is important to yourself to see what your colleagues are doing and those industry things are things that are being focused on at every meeting by other organizations, not just HHC.

Ms. Youssouf asked if there is anything we are missing? Mr. Martell answered no, that if there was something that is not being done here, it would actually end up in the corporate aspect of it. A lot of these things are just FYI to keep you informed and to keep the ball moving.

Ms. Youssouf asked if there anything about the prior year comments that we should be aware of? Mr. Martell said that they believe that the comments were cleared and there is a process in place to make sure that they continue with the ongoing recommendations.

Ms. Youssouf thanked them and asked for a motion to accept the Management Letter and it was seconded.

Ms. Youssouf then turned the presentation to Mr. Telano for the Internal Audits report.

Mr. Telano saluted the committee and began by stating that he will briefly discuss the audits on pages three and four, the City Comptroller's audits. There are four of them, and there has been minimal movement since the last meeting. They are still in the interviewing and gathering information stage. The audits are; the Emergency Wait Time, Navigant Billing Practices, the Lincoln Affiliation Agreement and the Patient Revenue and Accounts Receivable. There has been no discussion of findings as of this moment and they are just ongoing audits.

Board Chairman, Dr. Michael Stocker asked if there is any end to the Navigant audit. Mr. Telano responded that we have not heard from them in almost three months regarding this audit – no movement.

Mr. Telano moved onto the audits on pages five and six -- there were surprise cash counts done at Woodhull and the Greenpoint Community Center within a week of each other and the findings were discussed. Mr. Telano asked Mr. Rick Walker, North Brooklyn Network Chief Financial Officer to approach the table.

Mr. Telano continued by saying that one finding was found at both locations and that issue is regarding that the cashiers replace shortages with their own money and there is no log maintained to record overages and shortages, so there is no record as to the competency of the cashiers. The other issue regarding Woodhull was that cash was being moved to banks outside the facility and within the facility by the pharmacy cashier, unescorted by security or hospital police. Also at Woodhull, there were old metro cards before the rate went up valued at over $18,000 that had not been returned.

Mr. Telano continued and said that the issues related to Greenpoint was that there was minimal oversight of the cashier there. The clinical manager or the cashier supervisor who is located at Woodhull did not provide, on a daily basis or routine basis, some sort of oversight, and also that where the cashier is located, the workplace was accessible to numerous employees, and we believe there was a security issue there. Mr. Telano said that he will let Mr. Walker address those issues, if you want. Ms. Youssouf said yes, please.

Mr. Walker stated that that was quite a substantial audit, and actually he was at Woodhull all of five weeks when the audit took place and took corrective action to address each of them. For example, the cash exchange process was at Woodhull in which, with the supervisor's knowledge, someone would go to the bank to get change when they ran out, which was a long-standing practice that was identified. We have since coordinated with hospital police when, and if, that ever became necessary, we would be escorted by hospital police. More importantly, we got in touch with the controller's office and implemented a process we had at Harlem where we actually coordinated through our collections company, Carter, who would bring us change, which is even more appropriate for us. We are in the process of implementing those kinds of issues and then have the backup should something fall through and there was a need to go out, we would do that in a way that safeguarded the employees as well as the cash.

Mr. Walker stated that for each of the items, they went back and looked at the process, identified what the corporate policies were. In the case of the employee taking money out of their pocket, we in-serviced all the staff at the location as well as all cashiers performing the function that it was inappropriate for them to take cash from their person to correct any shortages -- that there was a reconciliation process now in place. Supervisors routinely sit down and go through this on a daily basis and we work with the staff to identify, if a shortage were to come up, that there is an indication that there is something in our process we need to address.

In terms of the off sites, Mr. Walker continued, we met with each of the managers and advised them that as managers they have a supervisory responsibility for the staff. In as much as the finance function, so we incorporated some reporting and routine reconciliation with the site manager where those cash functions existed. For two of the sites that were very small, they were small community-based clinics, located in housing facilities, which is pretty much like an apartment that is converted into a clinic; those sites were physically or logistically unable to meet the quote criteria for safeguarding cash. When we looked at the actual cash collected at these sites, we discontinued the cash collection, the reasoning is that we were collecting less than a thousand dollars a month, and when we went back and added the cost of the staff performing the function, it just did not pay for itself. We are billing all the patients with co-pays that we would otherwise have been collecting. This is

something we implemented in my prior life at Harlem and Renaissance Network that went very well and it did not disrupt our abilities to collect cash but also at the same time helped to better manage the limited resources we have available to manage.

Dr. Stocker asked how the increase on co-payment and coinsurance fit into that environment. Mr. Walker answered that most of the folks in HHC who would probably benefit from the exchange are the patients who are currently fee scale and they currently have co-pay and those persons who elect to make their payment, we were collecting those balances and we bill them and they are mailing in their payments. In that regard, I do not think there is going to be a material change for HHC, primarily the collections that we see are derived from those persons who are fee scaled and have those co-pays when visiting the center.

Dr. Stocker asked if they can pay by credit card. Mr. Walker said that they have the ability to pay by credit card.

Dr. Stocker asked if they can do it at the site. Mr. Walker responded that at the two sites they are not collecting cash that they would do it through the mail, but at all the sites it is actually by credit card or cash.

Then Dr. Stocker asked about the pharmacy. To which Mr. Walker answered that pharmacy is the same, we have a cashier at Woodhull and it is a full service cashier function.

Ms. Youssouf asked if they are finding that the payments coming in by mail equal the amount that was collected in cash. Mr. Walker responded that they have not done a comprehensive analysis that I can present to this committee. I guess we can go back and take a look at that after several months to see what is the variances in terms of what is in our lockbox versus what we otherwise are collecting in cash, but the size of those clinics and the amount of money we were collecting just did not support the FTE's that were allocated for that function.

Ms. Youssouf added that she just thinks that if, in fact, that number is going to increase, and then that is probably something you should take a look at, going forward. Mr. Walker answered by stating that we will take that into consideration and definitely take a look at it.

Mr. Telano continued his presentation by stating that the last report is on page seven of the briefing – it is the IT audit of the OTPS application and asked the representatives to please come up to the table.

Mr. Russo asked the representatives to identify themselves – they did as follows: Enrick Ramlakhan, Assistant Vice President for Business Applications and Jonathan Goffin, Director of Financial Analysis.

Mr. Telano said that within the briefing there are five areas that are discussed and he will go through them and maybe Mr. Ramlakhan can address them as he goes through them. The first one is about the user access controls, and have to do with the 18 generic user IDs and 54 user IDs that were created without the naming conventions, and then also four out five payroll department OTPS users that could create and update employee data, as well as print checks with the DEC system, which is more or less a sub of the OTPS. Also, the OTPS developer has full access to the production and testing areas which is a segregation of duty issues.

Mr. Ramlakhan remarked that all of the items, as outlined have been corrected. You have to realize, OTPS is a legacy application, and many of these pieces were not part of the base program. The team and Mr. Goffin's folks did an excellent job, they programmed and moved into production and they took the prerequisite corrective action.

Ms. Youssouf inquired and said that when you said it was not part of the legacy, even though you did not create it, isn't this stuff your department would be looking at anyway; because when you have a legacy issue, you always have to figure out what is actually functioning and what is not. Mr. Ramlakhan said absolutely, a lot of the things that a developer has to do are in production. We can do it in tests, but it also has to be migrated across and put into production, you also need access, so what we have done is, we have created a system and we have to run it by internal audit and they will get that access but they have to now go through change control. There has to be a remedy ticket already in place and then it needs to go through the business owners, the various approvals. Every time a developer goes into production, they have to have the access.

Dr. Stocker added that he is going to say something about the scope of internal audit, and that his background is definitely not internal audit. The way he sees internal audit is mostly from observation, and being on boards, is that their scope is broad and they can get into business issues. Like this recommendation about the reporting function in the system, which he agrees is probably old and difficult, and he is sure you have made many more request change systems than you have the ability to do it and you have to prioritize that. To him, it is reasonable for internal audits to say this is not functional or it could be better in terms of the utility of the reporting functions, but it is also reasonable information to say we have a long list of priorities – this is not like compliance where we have laws we have to avoid. We have a long list of priorities and we, management, will prioritize this in comparison to all the other things we have to prioritize. I think the access should not be restricted, but I think management wise, it is unusual for management to say it is just not in our priority list right now to do this and we understand your concerns.

Ms. Youssouf added that yes, while she thinks that is true, the question is internal audit's job is to one, find things that can use improvement and the business units are supposed to take back and respond appropriately saying yes, we understand that could use improvement. They are also there to keep you and us out of trouble, and the way they do that is to find things that are potential deficiencies or existing deficiencies with recommendations and how to change it so we stay out of trouble, because they are first defense against doing anything that could

potentially raise a giant red flag to all of the outside agencies and regulatory bodies that look at HHC. I want to make sure you guys understand that and that they will always have your full cooperation with anything they come up with and take it as a benefit, an extra set of eyes and ears to look at your systems.

Dr. Stocker said that we are kind of taking both sides of the same task, but an audit finding just by itself is not negative, it is called a recommendation. It is just that some recommendations are more important than others, but in the end it is really all recommendations.

Then Ms. Youssouf said that if it is something you strongly disagree with as a recommendation, you do not think it should happen, then the discussion should be escalated. But if it is not, your purview to just say no, we are going do it, because then that kind of defeats the point of an audit function.

Mr. Ramlakhan said he understood – and just wanted to clarify, some of the recommendations cannot be done solely by IT. We need the business input, that is what we meant by we cannot dramatically change these things without input.

Mr. Telano continued with the second issue – password controls not being effective. When an individual has to reset their password, OTPS only prevents them from reusing the last password. So they can go back two passwords or three passwords ago and use the same one. The password strength does not comply with HHC's information systems password policies and procedures. OTPS requires six non-case sensitive characters, the policy and procedures requires a minimum of eight. Also, there are no maximum numbers of times a user can unsuccessfully attempt to log into OTPS. We tested it and after five unsuccessful login attempts, the user was locked out of a specific terminal. However, they were able to login at another terminal right away.

Mr. Ramlakhan said that they have since done the programming and moved, migrated to production the necessary codes to ensure that this does not happen. The only piece is the three consecutive unsuccessful logins, which are still coding that, but it should be done by the end of the month.

Mr. Telano continued by stating that finance has not performed an annual reconciliation of vendor accounts payable because OTPS recognized accounts payable as all open purchase orders and the general ledger recognizes the AP liability as purchase orders where the goods were actually received, so there is a disconnect within those two systems.

Mr. Ramlakhan stated that they are working with the controller's office and are going to have a report that will address that issue, they are developing one.

Mr. Weiman said that actually, this is an issue that his office brought up to internal audits because we felt that it was necessary to have a tool to reconcile the two systems. Currently, we do other testing and test the transactions to make sure that everything comes across, but as a secondary tool, we needed it, so we appreciate the comment as well and we are working on it with IT.

Ms. Youssouf stated great and appreciates you bringing something up to internal audit.

Mr. Telano said that next issue is related to the expiration of timeout. For OTPS, currently it times out in two minutes, as compared to QuadraMed, which is another sensitive system, which times out in 15 minutes so we suggested that two minutes be increased.

Mr. Ramlakhan said that again they are working with the controller's office to get to that timing. We set the maximum at 15, so we have not violated the maximum. The minimum we have not set, so we are going to work with Mr. Weiman's team and get to that appropriate minimum timing.

Mr. Telano stated that the last issue is related to the reports and the statements, so he will not go into that. On page nine it shows that all of the auxiliary reports have been completed with minimal issues noted. Page 10 is the audits in progress, and page 11 is the follow-up audits, the status of them as of today.

Ms. Youssouf noted that on the auxiliary audits, a few had one, and another had five comments. Mr. Telano said that that was discussed at last meeting related to East New York in which they had a change of a new president being brought on board and that the new president was resolving those issues.

Mr. Telano said that unless there are any questions, that concludes his presentation.

Ms. Youssouf thanked him and said that it is time for Compliance.

Mr. Wayne McNulty saluted the Audit Committee and began by reviewing page three of the Corporate Compliance Report - compliance training results. He informed the Committee that, as of December 2, 2013, 21,200 of the 23,000 HHC staff members (who were designated to complete compliance training) received compliance training. He further explained that the personnel trained included physicians; all practitioners licensed under the Education Law, such as nurses, occupational therapists, respiratory therapists; and all Group 11 employees. He stated that 91 percent of HHC staff successfully completed training corporate-wide. Mr. McNulty continued by stating that, as of the beginning of December of 2013, 89.8 percent of all HHC and affiliate physicians received compliance training. He continued by discussing the

training numbers with regard to healthcare professionals. He informed the Committee that over 13,600 of the 15,000 healthcare professionals received compliance training; Mr. McNulty stated that the successful training rate for this group of individuals amounted to 91 percent corporate-wide. He added that with regard to the general workforce (Group 11 employees), 98 percent of all Group 11 employees successfully completed compliance training. He closed the topic surrounding the compliance training numbers by discussing the training of the HHC Board of Directors. He stated that nine members of the Board and six Board member designees were successfully trained.

Ms. Youssouf stated that she thinks it is great and Dr. Stocker added that one of the people is pretty new to the Board and he has committed to do that, and the others all know.

Mr. McNulty continued by turning to number two of the agenda – staffing update. He informed the Committee that there were two vacancies in the Office of Corporate Compliance ("OCC"), one in the North and Central Brooklyn Health Network and one in Central Office. Mr. McNulty expected that both of those positions would be filled within the next couple of weeks.

Mr. McNulty continued with the next topic of the report – Excluded Providers. Mr. McNulty reminded the Committee that he previously disclosed to the Committee that the OCC was made aware of an excluded attending dentist at Bellevue Hospital Center. He informed the Committee that the OCC made a self-disclosure report to the Office of the Medicaid Inspector General ("OMIG") and the United States Department of Health and Human Services Office of the Inspector General ("OIG"). He further informed the Committee that the OCC was contacted by both agencies. He stated that OMIG informed him that OMIG would not be looking into the matter further since the one Medicaid claim in question was subsequently denied. Mr. McNulty proceeded by discussing the OIG's communication with him on this matter. The OIG informed Mr. McNulty that, given the minuscule amount involved in the matter, the OIG would not be investigating the matter. Rather, Mr. McNulty explained, the OIG requested that the OCC contact HHC's Medicare fiscal intermediary to work out the return payment to Medicare. Mr. McNulty stated that the overpayment amounted to approximately a thousand to three thousand dollars.

Mr. McNulty concluded his report by requesting to discuss some compliance matters in executive session.

Capital Committee – December 12, 2013
As reported by Ms. Emily Youssouf

Ms. Youssouf advised that prior to addressing action items, a presentation regarding the new Henry J. Carter facility would be provided.

Robert Hughes, Executive Director, Coler Nursing Facility and Henry J. Carter Specialty Hospital and Nursing Facility, narrated a presentation which showed photos of the relocation that took place on November 24th and November 25th, and discussed the tracking process utilized to monitor the movement of patients from one site to the other. Mr. Hughes was joined by Floyd Long, Chief Operating Officer, and Michael Buchholz, Associate Executive Director.

Mr. Hughes advised that on Sunday, November 24, 2013, day one of the move, 114 hospital patients, 98 of which were on ventilators, were moved from the old Goldwater facility into the Long Term Acute Care Hospital (LTACH) at Henry J. Carter. The command center opened at 2:00 am, the first patient was moved at 4:00 am, and the relocation was complete just prior to 2:00 pm, approximately 20 minutes ahead of schedule. On day two of the move, 114 Skilled Nursing Facility (SNF) residents were relocated; the process began at 8:00 am, and was complete by 5:00 pm, several hours ahead of schedule. Patients were prepared for the move by unit staff, all patients had waffle cushions to help prevent pressure ulcers during transport, and successfully, as there were no incidents as a result.

Mr. Hughes explained that tracking of patients was done utilizing bracelets that were scanned at four different points throughout the process; 1) as patients left their original units; 2) as patients exited the facility; 3) as patients entered the new Henry J. Carter facility; and, 4) as they entered their new units, marking the end of their journey. The tracking was being viewed on an Electronic Patient Dashboard visible to persons in the command center, and it allowed real time monitoring of the process and each individual patient. The device was especially useful because, if it was detected that things were moving slowly on one end, it permitted for adjustments to be made accordingly.

Photos showed the main lobby, common areas, and patient rooms in both the LTACH and the SNF. Mr. Hughes noted that the new site features a library, a music and movement room, a culinary arts room, and a computer lab outfitted by donations from the facility's namesake Henry J. Carter.

Ms. Youssouf expressed gratitude that this project was coordinated and executed so well. She acknowledged the great leadership and team work that was needed, and expressed hope that the patients would be as pleased with the new site.

Mr. Hughes thanked Ms. Youssouf as well as the entire Board and Committee for their oversight and support over the course of the project.

Josephine Bolus, RN, said that documentation of this immense undertaking could and should be shared, so that it can be referenced if other facilities need to undergo a similar task. Ms. Youssouf, Antonio Martin, Executive Vice President, and Roslyn Weinstein Senior Assistant Vice President, agreed.

Senior Assistant Vice President's Report

Roslyn Weinstein, Senior Assistant Vice President, Office of the President, noted that the tracking system utilized in the relocation effort is part of a system used in response to a State mandate that was initiated post Hurricane Sandy, called e-finds. She explained that the system, which was tested on a small number of patients at Bellevue Hospital Center, is to be used to track patients in case of emergency, evacuation or any other patient movement. She added that publication of the relocation efforts, as previously discussed, would be investigated.

Ms. Weinstein provided an overview of the meeting agenda. She advised that there would be two action items, and a few brief status reports. Action items would include; 1) a lease agreement extension for space housing the Gun Hill Health Center, operated by Jacobi Medical Center; and 2) a license agreement for the Corporation's lobbyist to occupy space in Washington, D.C. Information items would include status updates on projects at Bellevue and Coney Island Hospitals.

That concluded her report.

Action Items:

Resolution - Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year lease extension agreement with Franciosa Owners, LLC (the "Landlord") for 5,300 square feet of space at 1012 East Gun Hill Road, Borough of the Bronx, to house the Gun Hill Health Center, operated by Jacobi Medical Center (the "Facility") at an initial rent of $29.78 per square foot to increase at 2.5% per year with the Corporation responsible for the payment of real estate taxes, water and sewer rents, and separately metered electricity provided that the Landlord shall perform renovation work which includes exterior storefront replacement, painting, and the installation of two new rooftop HVAC units and installation of a new water heater.

Diane Carr, Deputy Executive Director, North Bronx Health Network, read the resolution into the record on behalf of William Walsh, Senior Vice President, North Bronx Health Network. Ms. Carr was joined by Christopher Gowrie, Associate Executive Director, Richard Bernstock, Associate Executive Director, Beau Scelza, Associate Director, and Jean Burg, Chairman of the Department of Family Medicine, North Bronx Network.

Ms. Youssouf asked if the work to be completed on site was requested by Jacobi Medical Center. Mr. Scelza said yes.

Ms. Youssouf asked for an explanation of the anticipated increase in utilization. Mr. Bernstock explained evening and weekend hours may be extended, and added that services may be expanded to include specialty as well as general services, as the facility determines.

Ms. Youssouf asked if the site was easily accessible by public transportation. Ms. Burg said yes, there are multiple bus routes that stop right in front of the building and two subways that stop nearby.

Mrs. Bolus asked how many handicapped bathrooms are on site. Mr. Bernstock said there were two, and a handicap ramp provides access directly from the street into the lobby area.

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

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

Resolution - Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensee") to execute a three year revocable license agreement with Simon and Company (the "Licensor") for its continued use and occupancy of approximately 144 square feet of space including use of the reception area, conference room, library, storage area, kitchen, high-speed internet service and digital cable television at an occupancy fee rate of $1,494 per month or approximately $17,926 per year at 1660 L Street, N.W., Washington, D.C., for use by the Corporation's federal lobbyist.

Dion Wilson, Assistant Director, Office of Facilities Development, read the resolution into the record on behalf of LaRay Brown, Senior Vice President, Corporate Planning and Community Health.

Ms. Youssouf asked who the corporate lobbyist was, at present. Mr. Wilson said her name was Judy Chesser. Alan Aviles, President, said she was previously the lobbyist for the City of New York.

Mrs. Bolus noted that the rate seemed fair. Mr. Wilson explained that cable television, access to a library area, and a staffed reception area were all included in the fee.

Ms. Youssouf asked if there were other lobbyists in the same building. Mr. Wilson said yes, he believed so. Jeremy Berman, Deputy Counsel explained that some of the other tenants in the buildings were in fact lobbyists for other municipalities.

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

Information Items:

Project Status Reports

South Manhattan Health Network

Michael Rawlings, Associate Executive Director, Bellevue Hospital Center, provided a report on the expansion of the Inpatient Adolescent Psychiatric Unit at the facility. Mr. Rawlings advised that the project had been completed and the unit was occupied and in use. He noted that patients had been admitted and nine (9) of the fifteen (15) beds were already occupied. He advised that the project was on budget, was delayed only as a result of Hurricane Sandy, and was completed using Healthcare Efficiency Affordability Law (HEAL) 19 funds.

Southern Brooklyn/Staten Island Health Network

Daniel Collins, Director, Coney Island Hospital, provided reports for two projects at the facility.

- Boiler Plant Replacement – Mr. Collins said the project would be completed in May, 2014, additional work was ongoing, and the new slab would be poured in the coming weeks.

Ms. Youssouf asked how high the platforms would be raised. Mr. Collins said they would be raised thirteen (13) feet above sea level, which would fall between the 100 and 500 year flood plans. Alan Aviles, President, explained that building constraints were the reason the boilers would not be raised all the way to meet the 500 year flood plan.

- Conversion of 6-bedded Rooms to 4-bedded Rooms – Project completed in mid-October and occupancy is expected in December 2013.

That concluded the status reports.

Finance Committee – December 10, 2013
As reported by Mr. Bernard Rosen

Senior Vice President Report

Ms. Marlene Zurack informed the Committee that her report would include a brief update of HHC cash balance followed by a presentation requested by the Chair last month on the status of the healthcare Exchanges that will be presented by Julius Wool, Executive Director, Queens Hospital Center and Victor Bekker. The cash balance to-date is $300 million or 18 days of cash on hand (COH). The projected forecast for year-end is approximately $400 million or 24 days of COH. However there are some concerns that should be noted for the Committee, HHC is expecting $400 million in UPL payments in January 2014 and another $400 million in February 2014 both of which have not completed the approval process at the State and Federal level. To address this concern, HHC anticipates delaying its pension payment until the end of January 2014 as opposed to December 2013. HHC has been in contract with the State and Federal regarding this processing issue.

Board Chairman, Dr. Michael Stocker asked if the current status represented a major change from the previous reporting. Ms. Zurack stated that the issue has been escalated at both levels. However, LaRay Brown, Senior Vice President, Corporate Planning, Intergovernmental Relations, Community Health has been involved in resolving this issue and perhaps can provide the Committee with a status.

Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations, Ms. LaRay Brown stated that she has made calls at the federal level and they are fully aware of HHC's need; however, there is a level of review that must be undertaken as part of the process and HHC has been assured that the Supervisor of all the teams involved in this process will continue to track the flow so that there is no slippage.

Mr. Rosen asked for clarification of the year-end referenced by Ms. Zurack whether it related to fiscal or calendar year and how the projected cash balance for FY 14 compares to last year. Ms. Zurack stated that it is approximately $75 million higher.

Ms. Zurack stated that the next item would be the presentation of the Exchanges. Mr. Bekker is the sponsor for all of the work that is being done for the Exchanges and Mr. Wool participated in the first Breakthrough team which is reflective of the leadership engagement in this process, and Mr. Wool will report on the actual Breakthrough event.

Mr. Bekker stated that the work began on this project two months ago as part of Ms. Zurack's efforts to formulate a team to address the requirements of the Exchanges as part of the Affordable Care Act (ACA). There are a number of issues involved in the Medicaid enrollment process and how that will affect HHC's revenue is yet to be determined. There are the MAGI and the non-MAGI. HHC staff must be trained and certified as certified application counselor (CAC). There are seventeen plans in the State of NY. The CAC is similar to the Navigator except that the Navigators are funded through a federal grant. The coverage for MAGI is up to 65 years of age and CHP up to 400% of the federal poverty level (FPL). There is no asset test; however, the cap is $11,940.00.

Ms. Zurack added that the income requirement follows the IRS guidelines. Social security is not exempt if it is less than $25,000.00.

Ms. Youssouf asked whether social security counts. Mr. Bekker stated that over $25,000.

Mr. Rosen asked what the current FPL is. Mr. Bekker stated that it is $11,940.00 for a single person.

Mr. Aviles asked if those thresholds apply to dual eligible. Ms. Bekker stated that they do not.

Ms. Youssouf asked if child support count as part of the income. Mr. Bekker stated that it does not count.

Ms. Youssouf stated that as a point of clarification, page 3 does not count non-taxable income social security but it is social security greater than $25,000 that is included. Mr. Bekker stated that it is total income that must be greater than $25,000 in order for it to count as part of the asset.

Ms. Andrea Cohen, who represents Committee Member Deputy Mayor Linda Gibbs in a voting capacity, asked the difference between that process and the current one in terms of what the applicants are required to do and whether it is more complicated.

Mr. Bekker stated that it is more complicated with new rules. There are two different streams of Medicaid, MAGI and non-MAGI which will go to the local social service division and the MAGI will go through the Exchange portal.

Ms. Youssouf asked what TANF is. Ms. Zurack stated that it is Temporary Assistance for Needy Families. Mr. Bekker stated that one of the major challenges for HHC is to prepare its staff for the changes.

Ms. Youssouf stated that based on last month's reporting, the State would be taking over that role. Ms. Zurack stated that eventually the State will but not in FY 2014. Mr. Bekker stated that HHC's staff has been informed of the changes. The main goal is to protect HHC's revenue by keeping the patient base and providing access. There is a workgroup that will outline the process HHC will take that includes training of the staff and tracking.

Mr. Rosen asked who the navigators are. Mr. Bekker stated that the primary role of the navigators who were trained by the State is to assist individuals in accessing the Exchange portal and choosing a plan. The navigators were funded through the community based organizations (CBO).

Ms. Zurack stated that there was a grant NYS received from the federal government that allows CBOs to apply to become navigators. There was one hospital that won the award, Bronx Lebanon but aside from that hospital all of the navigators are very small CBOs. However, CSS received a state-wide grant to be navigators who are trained by the State. HHC has worked with CSS over the years on other managed care projects.

Ms. Youssouf asked if HHC pays the navigators. Mr. Bekker stated that HHC does not pay the navigators who are in HHC facilities.

Ms. Youssouf asked if the navigators will direct the patients to enroll in HHC's plan. Ms. Zurack stated that the navigators cannot and neither can the CACs/HCIs who are HHC staff. It is important to note that the navigators program is funded by the State and HHC has reached out to individuals on site to assist people. By regulation neither a navigator nor a CAC can steer patients to enroll in HHC's plan.

Ms. Youssouf asked if HHC's staff had to be conversant in all of the options. Mr. Bekker stated that it is a requirement.

Ms. Zurack stated that the process is not new in that all of the managed care staff and MetroPlus staff on site are required to inform the Medicaid recipients about all their options with or without HHC but they are not allowed to steer individuals to any plan.

Mr. Bekker stated that MetroPlus must be identified as a QHP.

Ms. Cohen added that it is the same as the Medicaid managed care process. Ms. Zurack agreed.

Mr. Bekker stated that MetroPlus has been involved in assisting HHC in getting the staff trained.

Ms. Zurack stated that HHC's internal group is comprised of representatives from the facilities, central office communications/marketing, finance, human resources, intergovernmental relations and MetroPlus. As Mr. Bekker stated MetroPlus has been extremely helpful in the training process particularly Dr. Saperstein, Roger Milner and Ryan Harris. Also there was representation from HRA, Linda Hacker, Karen Lane, and Mary Harper.

Mr. Bekker stated that as part of the recommendation from the workgroup, a 2P process was developed which Mr. Wool will present to the Committee.

Mr. Wool stated that the overall implementation of the ACA and the health Exchanges in NYS could be very positive. The State is projecting that 1.1 million of the 2.7 million uninsured will get health insurance through the health exchanges. As Mr. Bekker indicated there are some disadvantages and risks. The Breakthrough event included representation from all of the acute hospitals in HHC, subject matter experts from

MetroPlus, NYC Office of Management Budget and the NYC Human Resources Administration, various central office key divisions, information technology, managed care, revenue management and human resources. The initial event was focused on the inpatient application process. However, there is an event underway focusing on the outpatient application process. In the current state, there are approximately 190 employees who are hospital care investigators (HCI) in the acute care hospitals assisting patient in enrolling in Medicaid which generally covers the patient current inpatient admission.

Ms. Youssouf asked if the HCI was a new title. Mr. Wool stated that in the next few months those HCIs will be trained to become CACs. In terms of patients insured, the HCIs currently do a good job in the process of getting patients insured through Medicaid. Based on their work by identifying enrolling uninsured patients into a Medicaid plan, 97% of the inpatient patients get insured that is the result of processing 31,000 applications for inpatient in a year. What will change is that those HCIs must be trained and certified as CACs which is a 2.5 day process. HHC must train and certify its entire staff as CACs. At the same time, HHC must maintain the current level of productivity in doing as many applications given that the population will remain the same; however, the process changes to a twofold process. Some patients will be on line through the portal and some will be processed manually or on paper and in some instances both will be required for some patients. The current inpatient process of enrolling uninsured patients into Medicaid plans and the level of success at 97% generates $342 million annually.

Ms. Youssouf asked how HHC plans to maintain the current level given the complexity of the process.

Mr. Wool stated that it involves a process of tracking and monitoring the activity of the staff to ensure that the current levels of productivity is being maintained and making adjustment where applicable. In some instances it is more complex but like any new process there is a learning curve that once the staff gets pass that stage it is expected that the process will glow more smoothly. Additionally, some of the verification and income information will be automated which is expected to improve the process. The goal is to maintain the current level of processing applications so as not to affect HHC's current revenue flow.

Ms. Zurack stated that the complexity of the process relates to determining income for patients; however, as Mr. Bekker stated the asset test in no longer required which is less work. In the current process there are numerous documentation requirements which are more labor intense and more paper driven in term of the income verification. Under the new health Exchanges this is no longer a requirement.

Ms. Youssouf asked how the income will be verified. Mr. Bekker stated that it will be through the IRS.

Ms. Zurack stated that the complexity also involves the individual's ability to provide the same level of income as reported on the individuals' tax return. In the current process, the verification is based on the required documentation or proof of income such as a paystub, which involves more steps but less complicated in terms of having to assist individuals in the new process of providing income that is consistent with that individual tax return last filing.

Mr. Bekker added that it will also go through Homeland Security in addition to IRS.

Ms. Cohen asked if there is a discrepancy would the CACs be involved in reconciling the issue with the individual. Mr. Wool stated that it is built into the process.

Ms. Youssouf asked where the 31,000 came from. Mr. Wool stated that it is the prior year total application submissions. Ms. Youssouf asked if it has been a steady 31,000 given that there were some repeaters. Ms. Zurack stated that there have been some repeaters but the new process will assist in addressing that issue.

Mr. Wool stated that once a patient gets permanent insurance as part of the 1.1 million expansion projected by the State, those individuals will come to the facilities with insurance. Therefore ultimately as the process moves forward, the expectation is that the number should go down. The other factor that is contributing to the complexity of the process is focusing on the Medicaid and emergency Medicaid to cover the current admissions. In addition to those efforts by the staff, the HCI/CAC will also have the added responsibility of assisting patients in selecting a permanent insurance plan with all of the options that range from plans, various products various levels of co-pays/deductibles, based on the network each plan offers. The individual/patient must access that network which is a new process for the inpatient stay. The process was a function done historically by the outpatient HCI staff but for the inpatient HCI/CAC it would be an expansion of their role that requires the appropriate training. There were a number of phase that were covered as part of the Breaththrough process. The initial phase included understanding the gaps and the need requirements. The goal was to develop standard work for the new process for the inpatient CACs and to ensure that by January 1, 2014, HHC is on target to go live with the new enrollment system. It was important that the new standard work that was developed is flexible and adaptable in order to allow the staff sufficient time to work through the issues that are changing on a daily basis. A flow chart was created to identify the major steps involved in the process that included the identification of the uninsured patients, on a 24/7 basis following the process previously initiated. The standard work was identified for the CACs through a two-stage process that involved identifying the best possible simplest process for getting the end result choosing the best element from each of standard work processes that became the one single best process. The implementation of that process will include scripts that will be provided for all the CACs to ensure consistency in the flow process. A scheduling process map or vertical value stream was developed that will take HHC from the current stage to the 1st quarter of the new calendar year in terms of a schedule of activities including staff training and information technology support, whereby there will be computers on the units to assist patient in enrolling. HHC is in the process of modifying the job description for the HCI, a communication plan and a monitoring plan for the staff.

Ms. Youssouf asked if there is a standard program provided by the State that will be used. Mr. Wool stated that it is in the NYS portal which is the same program used by the navigators.

Mr. Rosen asked what the deadline is for the completion of this process to which Mr. Wool responded that HHC must be fully prepared by January 1, 2014. The staff must be trained and the standard work must be in place by that date.

Mr. Rosen asked if overtime would be required for the staff to meet that deadline. Ms. Zurack stated that at this time it would not.

Mr. Wool stated that in terms of the process preparation event, a detailed standard work was developed in addition to process flows, scripting for the staff interaction with the patients. There is a change management plan which will be a very dynamic process over the next six months. A communication plan is also required in order to successfully achieve the goal of the new requirements of the healthcare exchanges.

Mr. Bekker stated that Mr. Wool had taken the Committee through the inpatient process; however, as of that day there was an outpatient process taking place and would be completed by the end of the week. Following the completion of that process there would be four kickoff events for each of the boroughs excluding Staten Island. The purpose of those events is to inform and distribute to the staff the new standard work, and scripts that were developed by the Breakthrough team.

Mr. Bekker stated that to-date HHC has trained 117 HHCs with an additional training underway for 37 staff that is being conducted by MetroPlus for a total of 154 staff trained by end of the week. HHC is negotiating with the State for additional training sessions.

Ms. Zurack stated that HHC's intermediary in getting the staff trained has been GNYHA who has been extremely helpful most notably, Stuart Presser of GNYHA.

Mr. Bekker stated that the target is to train approximately 700 HHC staff through a two-step process; initial training by the State of HHC staff resulting in train-the-trainer staff that will then train HHC staff.

Ms. Zurack addressing Mr. Rosen's concern regarding HHC meeting the requirement by the January 1, 2014 deadline stated that MetroPlus is on HHC's Steering Committee and is currently doing the new applications and based on their feedback, the new process takes approximately forty-five minutes.

Mr. Bekker stated that MetroPlus has enrolled 5,038 individuals into their plan. Statewide the total enrollment is 91,103 of which half are Medicaid and the remainder is QHP. In terms of the MetroPlus enrollment the majority is young individuals and will most likely go into a QHP.

Mr. Aviles stated that as per Dr. Saperstein, MetroPlus has enrolled 6,700.

Ms. Cohen asked if MetroPlus has a target. Mr. Bekker stated that the target is 40,000 by year-end. It is important to note that the enrollment is the enrollment and coverage is only when the individual pays the premium.

Ms. Youssouf asked what enrollment means in terms of approval. Mr. Bekker stated that it means that the individual has selected a plan and the coverage is pending until the premium is paid.

Ms. Cohen asked how the eligibility process works given that there is a big discrepancy in those who have completed applications and those who have enrolled.

Mr. Bekker stated that those individuals would be required to go back and select and pay the premium.

Ms. Zurack stated that part of the problem could be that there are more options to choose from and in deciding which option to choose, individuals may be deciding which one would be the cheapest and may not be selecting an option upon the initial enrollment.

Mr. Aviles asked if there is a grace period given that the coverage goes into effect the first month of payment. Mr. Bekker stated that there is a 90-day grace period for the second part.

Mr. Aviles asked if the coverage continues even if no payment was received.

Mr. Bekker stated that it would be up to the discretion of HHC. The State is currently reviewing this issue. There are a number of issues that cannot be resolved at this time; therefore it is a work in progress.

Ms. Zurack stated that this is a major issue given that individuals can buy insurance and only make one payment and not make the second. HHC has been advised that the plan is not obligated to pay the hospital and that the hospital can bill the patient after the second month. However, the mechanics of that will be difficult for HHC.

Dr. Stocker stated that based on information regarding that process, the hospital cannot bill the patient.

Ms. Zurack stated that the patient is allowed to pay their premium to be reinstated.

Dr. Stocker stated that some hospitals are deciding whether to pay the premium on behalf of the patient.

Mr. Aviles added that given that possibility, HHC needs to be prepared to act very quickly when a patient is in that situation so that the individual can be persuaded to pay their premium to have the retroactive coverage.

Mr. Bekker stated that there is a fifteen day grace period for the patient to pay the premium. However, HHC is working with its legal counsel to build incentives as part of the process. It is important to note that Secretary Sibelius indicated that the Exchanges are not the federal government's problem and are not covered by the Stark Law; therefore, it may be possible for HHC to make some payments on behalf of the patients.

Mr. Aviles stated that theoretically HHC can make the necessary payment on behalf of the patient in order to get the retroactive coverage so that the cost of the inpatient stay, $20,000 will be paid based on a $115.00 premium for the patient.

Ms. Zurack stated that at one of the seminars attended by Mr. Bekker and other staff, the attorney from one of HHC's legal firms provided the training. HHC has developed a workgroup that includes legal counsel, intergovernmental relations and finance to address this issue.

Dr. Stocker added that in addition to the Stark's Law there is the issue of fraud. Mr. Bekker agreed with Dr. Stocker.

Dr. Stocker stated that there are a number of legal requirements about whether providers can waive or pay on behalf of the patient. The department of Justice would consider some things fraudulent. There is a financial determination made to set a rate and certain behaviors are expected based on co-pays and deductibles and if waived there would be a different economic outcome that would be taxpayers monies.

Mr. Russo agreed adding that the information Mr. Bekker provided from the HANYS briefing that Fred Miller from Garfunkel Wild, PC had been the speaker included some cases above and beyond fraud. Some of the cases held that in fact if a hospital depending on the language of the contract waived the co-payment that would actually be altered and did not trigger the right of the hospital to get reimbursement given that the contract was altered.

Dr. Stocker asked Mr. Russo for clarification. Mr. Russo stated that the contract for insurance assumes that there will be a co-payment and deductible made. If the hospitals unilaterally waived them there is a line of cases that states that the contract was altered and the obligation for the insurance company to pay the hospital has been altered and therefore does not have a right to the reimbursement.

Ms. Youssouf asked whether the hospital can offer to pay the premium. Mr. Aviles interjected that the discussion was getting into a level of detail that could not be resolved or addressed appropriately at that time but that perhaps in the month ahead, some of the Committee's concerns can be addressed as information becomes available.

Ms. Zurack stated that in preparation for HHC's incentive meeting, information was shared with HHC's senior leadership that addresses what a patient paid on Options versus a premium cost versus what a tax penalty would be. The group will be reviewing that information along with the slides from Mr. Miller and the latitude of the options in attempting to develop the appropriate protocols that will protect HHC's patients and incentivize individuals to enroll in the Exchanges.

Dr. Stocker added that there are some patient advocacy groups that have indicated that they would pay the premium or the co-pay/deductible or a combination of both which sometimes is done on the commercial side.

Mr. Russo stated that option is included in the information that will be covered as part of the incentive workgroup that requires further review.

Key Indicators/Cash Receipts & Disbursements Reports

Ms. Krista Olson informed the Committee that Mr. Covino was on jury duty and that she would be covering both reports beginning with the Key Indicators. Outpatient visits were up by 1.7% at the acute hospitals up 1.4% over last year and the diagnostic and treatment center (D&TC) visits are up by 4.2%. Acute discharges are down by 4.5% and nursing home days are down by 15.8%. The average length of stay (ALOS), there were two facilities above the expected ALOS, Kings County remained high at 7/10 day over and Coney Island 4/10 day. Three facilities were below the expected ALOS, Harlem at 4/10, and Lincoln 7/10 less than the average and Metropolitan was also less. The case mix index (CMI) was up .84% compared to last year. The budget performance through October 2013, FTEs are up 133.5. Last year HHC ended the year 700 FTEs less than the target. The increase for FY 14 is primarily related to new hires for the Patient Centered Medical Home and Enterprise IT. Receipts were $106.3 million worse than budget and disbursements was $38.6 million worse for a total year-to-date deficit of $144.9 million through October 2013. The FY 14 actuals compared to the prior year for the same reporting period, receipts were $438 million less than last year primarily due to the timing of the FY 13 DSH payments. HHC received $624 million for DSH last year compared to this FY 14, $152 million and $194 million was received. Expenses were $48.8 million better than last year due to the timing of City payments.

Mr. Rosen asked if the negative variance was attributable to the timing of the DSH payments. Ms. Olson stated that HHC is expecting an additional $520 million next April 2014. However, compared to last year in total of $1.1 billion that included the "spend-up" this year without that one-time adjustment the expected total projection is $866 million. Continuing with the reporting, current actuals versus the budget are down by $79 million in inpatient receipts due to a decline in the Medicaid fee-for-service down by $49.7 million; Medicaid managed care down by $21.7 million and Medicare by $7.7 million. Outpatient receipts are downy by $33 million and all other is up $5 million. Expenses were over budget by $5.3 million due to the transitioning at Coler/Goldwater. Fringe benefits were $2.4 million better due to a FICA refund. OTPS was

$38 million worse than budget due in part to payments made for the restoration of services at Bellevue, Coney Island and Coler due to the storm last year.

Action Item:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Hawkins Delafield & Wood LLP ("Hawkins") to provide bond counsel services related to the structuring and continuing implementation of the Corporation's financing program for the period beginning December 1, 2013 through November 30, 2016, plus two one-year renewal options solely exercisable by the Corporation. The hourly rates are: $420 for Partners, $360 for Senior Associates, $280 for Associates, $210 for Junior Associates, and $150 for paraprofessionals.

Ms. Dehart introduced Steve Donovan of Hawkins Delafield & Wood LLP who was representing the firm. As part of the solicitation process, pursuant to HHC's operating procedure, a request for proposals (RFP) was conducted to select bond counsel services for HHC. The RFP Committee consisted of representatives from central office finance, NYC Comptroller's office, NY OMB, legal counsel and Bellevue. Hawkins was selected by the Committee for the continuation of HHC bond counsel services. Hawkins has served as HHC's bond counsel since 1995 and has successfully represented HHC in a number of issuances in other matters.

Mr. Rosen added that the rates are reflective of a discount which has been the standard in the past. Mr. Donovan stated that the rates reflect a 40% discount.

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

Information Item:

Statement of Revenues & Expenses as of September 2013 & 2012

Mr. Jay Weinman brought to the attention of the Committee the year-to-date net loss of $53 million for 2014 and $114 million in 2013. Some of the major variance highlighted began with the net patient service revenue that increased by $71 million over last year due to $135 million for retroactive income; $70 million for UPL and $31 million for DSH maximization. Additionally, there were decreases in revenue of $72 million, $26 million in outpatient due to a change in the estimate for accounts receivable that was made year-end in FY 13 and brought forward this year. Thirty three million was related to a decrease in inpatient revenue. Premium revenue decreased by $28 million or 5%. MetroPlus' rates increased by 8% due to services while membership decreased by 3%. Personal Services (PS) increased by $14 million or 2.3% due to last year's reduction of $23 million in collective bargaining based on estimates consistent with the City which decreased last year's expenses compared to this year's increase. There was a decrease of 375 FTEs or 1% and other than personal services (OTPS) increased by $51 million of which $36 million was related to an increase in MetroPlus services cost and HHC expenses of $10 million that was a carryover from last year. Medical and non-medical services increased by $2 million.

Ms. Youssouf asked for clarification of the FTE increase. Ms. Zurack stated that Mr. Weinman and Ms. Olson's reporting periods were different, September 2013 and October 2013 respectively.

Mr. Weinman continuing with the reporting stated that the postemployment benefits, other than pension decreased by $21 million which is consistent with the City's actuary estimation from last year that decreased expenses. The report was concluded.

Dr. Stocker asked about the outpatient data on the utilization report that is distributed to the Board. Ms. Zurack stated that the purpose of the data in terms of the healthcare transformation would require different data that would perhaps be more useful to the Board in addressing some of questions raised by Dr. Stocker relative to the 60% and 35% capitated; capitation discharged per 1,000; and hospitals' utilization as it relates to low occupancy. Ms. Olson has been working on restructuring some of the reporting in that area. It would be useful if the Committee could make some suggestions in terms of what type of data it would find more useful.

Ms. Youssouf asked what was the status of the request for the distribution of the DSH funding and the impact on HHC for those hospitals that were closed.

Ms. Zurack stated that corporate finance in conjunction with Ms. Brown is working on putting together data relative to the changes due to those closures.

Mr. Rosen extended holiday wishes on behalf of the Committee.

Medical & Professional Affairs / Information Technology Committee
- December 12, 2013 – As reported by Dr. Michael Stocker

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

Managed Behavioral Health

The project on the Reduction of Length of Stay continues; there will be another Learning Session; there was an average of 20% reduction in the Length of Stay. Woodhull, Lincoln and Metropolitan have almost reached the national baseline of 12 days.

Accountable Care Organization (ACO)

ACO has had a number of activities. More detailed information is available from CMS. There are about 12,200 beneficiaries, with 1000 newly attributed in the last round of information. Year 2013 is the reporting year and responsibility for performance is capture in the first meeting in 2014. To date the reporting process is automatically in place with the help of an external vendor. Work has commenced with each of the facilities to assist with manual extraction of some of these measures. It will continue to be a manual burden until the transition to EPIC. The ACO has established Governance and Audit Committees as required by the Public Authorities Accountability Act. They are also working on its compliance and management plans. We have identified local Physician Champions at 14 out of the 17 facilities and we have been conducting kick-off presentations with the physicians involved treating the beneficiaries.

Institute for Medical Simulation and Learning (IMSAL)

IMSAL has been aiming to strategically increase its reach and efficiency. We are creating a more distributive model for the Institute whereby each facility has a lead person who is in training, appropriate space, and equipment. IMSAL is controlling the curriculum and the standardization of how things are taught.

Influenza Vaccination

Currently 76% of our employees are vaccinated (approximately 28,000 employees); another 14,500 contractors, volunteers etc. are vaccinated as well. This is a considerable progress from previous years. Special recognition is given to the employees who have gotten vaccinated for the first time.

The 2013 Patient Safety Forum

On December 11, 2013 at Jacobi Medical Center, the President outlined the improvements we accomplished in patient safety over the past five years

Chief Information Officer Report
Bert Robles, Senior Vice President, Enterprise IT Services

ICIS Electronic Health Record (EHR) Program Update

EPIC Implementation
Stage 3 (the build and design of content delivery) has approximately 16 teams involved.

The Soarian and EPIC environments integration continues. The migration of the existing QuadraMed data to create the design and build the architecture to preserve the existing data which will need to be carried over to the new Electronic Medical Record is in process.

The upgrade to EPIC's version 2014 has been completed. We are in the process of training the workforce for recertification in the new version as requirement. We are in the process of identifying the SMEs that will help deliver content. The Queens Health Network will be the first site for deployment, scheduled for November 2014. Ms. Emily Youssouf asked if the SMEs and team members are internal to HHC. Mr. Robles said that the SMEs are principally from within HHC, from various facilities. The application folks are hired consultants (both EPIC and third parties). The end user training kick-off meeting took place on December 3rd at Harlem Hospital.

We continue to track the key dependencies: Soarian, NSLIJ Joint Venture and ICD-10 are critical.

As of today, we are on time, on budget and will continue to discuss the possibilities of retaining FTEs instead of increasing OTPS spending. Ms. Bolus asked how we could retain FTEs. Mr. Robles indicated that retaining FTEs is somewhat difficult as recruiting in the field is ongoing at Mount Sinai and the economy is a little better, which makes recruiting and retaining harder for us. Mr. Robles is an advocate of structuring programs that help retain staff. Ms. Youssuf suggested that we could perhaps look at working with schools to offer unpaid internships. Mr. Robles said that we have been exploring this avenue and we will continue to do so.

The Fire Department
We have deployed wireless technologies to allow for document transmissions for registration and vital information directly from the ambulance to the hospital facility, emergency room and eventually to HHC electronic medical record system to eliminate paper and increase patient care. We currently have eight (8) sites up. We expect to have the remaining group completed by the first quarter of 2014.

Meaningful Use
This past September concluded the second year that HHC has participated in the Federal Program for Meaningful Use of electronic medical records. We are pleased to report that again, all eleven of HHC"s Acute Care facilities met or exceeded the minimum thresholds to qualify for

Federal Fiscal Year 13 Meaningful Use Incentive Program payments. This achievement reflects continued hard work by the facility clinical staff to use the electronic medical records in a meaningful way. All attestations for this program were entered into the Center for Medicare and Medicaid Services website by our colleagues in Finance by the November 30th deadline. HHC's anticipated incentive for this year of the program is $47.6 million for the combined Medicare and Medicaid program components.

Notwithstanding this achievement, HHC continues to focus on meaningful use. As you may know, the Federal Government has begun to audit this national program and some providers have had to refund their MU incentive dollars. Three (3) HHC facilities (Metropolitan, Kings County and Woodhull Hospitals) have been selected for audits. HHC had planned for potential audits and each facility was able to efficiently respond to the first round of audit questions. A second round of questions has begun.

In addition to audits, HHC is getting ready for MU Stage II. As was the case with Stage I, MU will require significant software updates supplied by our vendor, QuadraMed. HHC is currently involved in a Beta test of the new QuadraMed software at Jacobi Medical Center and the code has had some significant issues, requiring two delays of software go live. HHC has worked closely with the facility and the vendor to resolve as many issues as possible. This activity is important insofar as the MU time-frame is very tight, requiring all facilities to attest by the quarter ending September 30, 2014. The total additional incentive money at risk for Stage II is $17 million.

Action Items:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to enter into a contract to purchase software, hardware, services and corresponding maintenance for a biomedical middleware software solution with iSirona, LLC (the "Contractor"). through a Federal General Services Administration ("GSA") contract in an amount not to exceed $6,454,161, which includes a 10% contingency of $586,742 for a one year term with four one-year options to renew at the Corporation's exclusive option.

Presenting to the Committee were Mr. Paul Contino, Chief Technology Officer, and representatives of iSirona LLC.

The purpose of this contract is for the procurement of a piece of software that is for medical device integration. It allows us to connect a whole host of medical devices to our EMR and streamline that data directly. The funding for this purchase is part of the overall EPIC budget. This is a required component of the EHR system.

Currently, the data from these devices is being entered manually into the EMR allowing for the possibility of transcription errors, patient ID errors, delayed documentation data, etc. The proposed contract will allow the Corporation to implement a solution that will automatically take the critical patient data from these devices and send the results to the EMR. This solution will greatly improve the efficiency of the Corporation's clinicians and improve patient safety by enabling automatic updates rather than manual updates to a patient's EMR. The Corporation issued a biomedical middleware software and services RFP to which the Contractor responded. The Contractor is able to provide middleware software and hardware, which will be used to integrate the Corporation's biomedical devices with the EMR system utilizing the InterSystems Ensemble Integration engine. The overall responsibility for managing and monitoring the agreement shall be under the Senior Vice President/Corporation Chief Information Officer.

This resolution was approved for consideration by the full Board of Directors.

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute contracts with various authorized resellers on an on-going basis over a one year period for the purchase of Cisco networking equipment and software through NYS Office of General Services ("OGS") contracts in an amount not to exceed $4,188,853, which includes a 20% contingency.

Presenting to the Committee was Mr. Sal Guido, Assistant Vice President of Infrastructure Services.

The Corporation has several hundred servers to support the Corporation's new electronic medical record (EMR) system, which are utilized to manage clinical, financial and administrative data throughout the Corporation to support business and clinical applications pertaining to patient care. The Cisco networking equipment and software are required to connect the various servers holding EMR data into the Corporation's network. Failure to obtain this equipment and software for the Corporation's network will result in the inability to deploy the EMR system with adverse impacts on patient care. The Corporation will solicit proposals from Cisco Inc.'s authorized resellers who offer Cisco equipment and software for sale through OGS contracts. OGS contract prices for such equipment and software are discounted from market price. Contracts will be issued to the OGS vendors offering the lowest price for the requested equipment and software. The overall responsibility for managing and monitoring these contracts shall be under the Senior Vice President/Corporate Chief Information Officer.
This resolution was approved for consideration by the full Board of Directors.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to purchase from Dyntek Services, Inc. (the "Vendor") through a NYS Office of General Services ("OGS") contract F5 Load Balancers hardware, software and services in an amount not to exceed $4,448,182, which includes a 15% contingency of $580,198.

Presenting to the Committee were Mr. Sal Guido, Assistant Vice President of Infrastructure Services, and representatives from Dyntek Services, Inc.

This is a request for authorization to purchase an F5 Load Balancing Solution through the EMR budget previously presented to the Board of Directors. On September 27, 2012 Enterprise IT Services (EITS) presented the Epic contract to the Board of Directors for approval. In the presentation to the Board, EITS advised that multiple future contracts needed to complete the transition to the new EMR would be presented to the Board of Directors. As listed on slide 14 of that presentation to the Board, the total projected cost for the EMR program over a 15 year period is approximately $1.4 billion.

The Corporation has an immense inventory of routers, switches, firewalls, servers and wireless controllers, which are utilized to link various computers and data systems throughout the Corporation together to share business and clinical applications used for patient care; and the F5 Load Balancers are required to avoid outages associated with traffic congestion over the network. Failure to obtain such hardware, software and services for the Corporation's network infrastructure may result in system unavailability with an adverse impact on patient care. The subject acquisition is needed for the network infrastructure to support the Electronic Medical Record program; The Corporation solicited proposals from vendors who offer their equipment, software and services via the OGS and Federal General Services Administration contracts. The Vendor, Dyntek Services, Inc. offered the lowest price for the requested equipment, software and services. The overall responsibility for managing and monitoring the agreement shall be under the Senior Vice President/Corporate Chief Information Officer.

This resolution was approved for consideration by the full Board of Directors.

Authorizing the President to negotiate and execute a contract between the New York City Health and Hospitals Corporation (HHC or Corporation) and CareFusion Solutions, LLC ("CareFusion"), to provide automated medication dispensing systems used in the administration of medication and supplies. The proposed contract is an enhanced Premier contract PPPH14CFS that would standardize the cost, support, services and at the same time set an end date for all current active contracts. Currently we spend $23,921,500 on automated medication dispensing systems and we need $4,848,048 in upgrades and additional fees. By doing a single overall contract rather than multiple smaller contracts the Corporation would save $5,458,240 over the term of the contract, or $1,091,648 annually. The five (5) year contract cost is $24,447,347 for existing equipment and 73 new rental units. A Contingency of 20% ($4,889,470) has been included to provide expansion opportunities for a total not to exceed amount of $29,336,817.

Presenting to the Committee was Mr. Antonio Martin, Executive Vice President and Chief Operating Officer.

This is a request to enter into a new contract with CareFusion for its Pyxis MedStation and supply cabinets. The proposed contract, an enhanced Premier contract PPPH14CFS, will be for a term of five (5) years and standardize pricing for equipment, products, services and support across all the facilities at HHC. The contract shall be an amount of $24,447,347 and a 20% contingency of $4,889,470 for an amount not to exceed $29,336,817.

Today there are over 290 Pyxis MedStation units installed across 10 NYC facilities at a current cost of $4,784,300 per year. These facilities, along with the new Henry J Carter facility, need to be on the same configuration platform for both equipment and service/support at a lower cost with the ability to acquire more equipment at a lower cost.

The Pyxis MedStation system is an automated dispensing system supporting decentralized medication management to improve patient safety. Barcode scanning helps ensure accurate medication dispensing. Its features are designed to prevent loading of the wrong medication along with active alerts for high risk medication and help manage medications at risk of diversion, at risk of being diverted from their intended use.

A decentralized automated medication distribution systems allows HHC clinicians to deliver the right medication in the right dosage/form at the right time to the right patient that improves patient outcomes to mitigate adverse events.

A new five year contract would standardize the cost, support, services and conterminously set an end date for all the incorporated contracts with a discount of 57% for all units with a total savings under the contract term of $5,458,240 or $1,091,648 annually. An assessment shall be conducted to determine present and future needs during the term of the agreement by the Pyxis Advisory team comprised of Director of Pharmacy, Office of the Chief Medical Officer, Office of Procurement and EITS representatives. The Executive Vice President/COO shall be responsible for the overall management, monitoring and enforcement of the contract.

This resolution was approved for consideration by the full Board of Directors.

Information Items:

MetroPlus Health Plan Annual Report

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 December 3, 2013 was 419,080. MetroPlus membership has dropped 5% in the last 12 months (21,605 members lost). Breakdown of the plan enrollment by line of business is as follows:

Line of Business	# of Members	
	December 3rd, 2012	December 3rd, 2013
Medicaid	375,094	357,056
Family Health Plus	36,100	33,390
Child Health Plus	14,479	12,086
Medicaid HIV SNP	5,698	5,367
Medicare	6,191	7,465
MetroPlus Gold	3,123	3,286
MLTC	0	430
Total	440,685	419,080

The decrease in membership is attributed to several factors: loss of membership after change in dental vendor, loss of membership to Healthfirst and Fidelis, involuntary disenrollment due to loss of Medicaid eligibility, third party health insurance reconciliation, and HRA backlog. Some of the strategies we employ to address losses are changes in the marketing strategies and increased outreach to members for recertification.

MetroPlus has 17,374 provider sites as of December 3rd, 2013. HHC PCPs have declined in the past, but we have seen an increase this year from 517 to 554 as of the second quarter of the year.

The continued growth of MetroPlus and our expansion into new lines of business will allow for the capture of new populations. We will assist HHC in maintaining their patient and revenue base while HHC assumes full risk for all members who select an HHC site. HHC assumes risk for all the medical care other than primary care provider. MetroPlus assumes full risk for all members assigned to a primary care provider not affiliated with the HHC network and for all members in Medicaid HIV SNP and Medicare plans. This arrangement allows for the alignment of incentives: Improved outcomes and decreased utilization benefits both MetroPlus and HHC. This is also an Opportunity to maximize the percentage of plan revenue payable to HHC. The lessons learned from years of partnership will allow MetroPlus and HHC to successfully develop and operate an Accountable Care Organization (ACO) model of care.
MetroPlus has been rated the #1 Medicaid Managed Care health plan in NYC for seven out of the last eight years. For the first time ever, in 2011, MetroPlus was ranked #1 in New York State and New York City.

Managed Long Term Care (MLTC) Overview

MetroPlus began offering full services for enrolled members as of January 2013 and received our first auto-assigned members in February 2013.

Managed Long-Term Care (MLTC) offers assistance to people who are chronically ill or have disabilities and who need health and long-term care services, such as home care or adult day care. The goal of the MLTC plan is to allow these individuals to stay in their homes and communities as long as possible. The MetroPlus MLTC plan arranges and pays for a large selection of health and social services, and provides choice and flexibility in obtaining needed services from one place.

Our current membership is 430 MLTC members.

Fully Integrated Duals Advantage (FIDA)

FIDA is a State of NY partnership with CMS to test a new model for providing Medicare-Medicaid enrollees with more coordinated, person centered care experience. Enrollment will be phased in over several months beginning in 2014; beneficiaries receiving community-based long-term services and supports will be able to opt in to the demonstration beginning on July 1, 2014; eligible beneficiaries who have not made a choice to opt in or out will be assigned to a Medicare-Medicaid Plan through a process that will match beneficiaries with the most appropriate plan beginning on September 1, 2014. Those who have not made a choice to opt in or out will be assigned to a Medicare-Medicaid Plan beginning no earlier than January 1, 2015.

New York Health Exchange

MetroPlus offers a total of 38 products across the individual and SHOP markets. MetroPlus also offers the lowest cost products in three out of four metal levels. We have approximately 5000 current applicants with completed applications.

Challenges

Dr. Saperstein indicated that challenges are, securing access for our new exchange membership HHC Access Project. Managing utilization and costs in the exchange products. 2015 Exchange Bid due in March 2014 before any real utilization data available.

HHC Access Improvement Initiative
Presenter: Christina Jenkins, MD, Sr. Assistant Vice President, Quality, Performance and Innovation

Improving access is a top corporate priority and an essential precursor to improving health and reducing costs. Access improvement is strategically vital to our ambulatory care redesign efforts, increasing our managed care population, and achieving the benefits of an Accountable Care Organization (ACO). The work of preparing our delivery system to better serve our patients is supported via engagement with McKinsey + Company.

To date, there is a validated 20-25% capacity opportunity at existing resource levels across the Corporation. Patients experience a number of frustrations in the scheduling process.

We have conducted the project at six pilot facilities and we have seen a 25% decrease in average wait times for new visits in adult medicine, pediatrics, and adult mental health clinics. There has also been a 20% decrease in average wait times for new visits across subspecialty clinics. We also have qualitative and data-backed evidence of excellence and high engagement.

Access work is underway in 13 of 17 facilities. We will complete rollout by the first week in January 2014.

In order to sustain success and "unlock" the 20-25% capacity within our facilities, we need the following:

- Automated Soarian reporting on key performance metrics.
- High performing call center capabilities.
- Alignment of resources to support continuous performance improvement.

We will also need to strengthen the community provider network around facilities of high-risk.

Dr. Amanda Parsons asked what kind of guidance we are offering physicians in order to maximize access. Dr. Jenkins said that we are operating on the principles of the Patient Centered Medical Home. Everyone is working at the top of their license so the physician can have additional time to improve the quality of care while decreasing wait times.

Dr. Wilson indicated that this is an incredibly ambitious scale of work. The commitment needs to be sustained. Automated Soarian reporting is crucial to maintain the momentum. We also need to combine the call center with care coordination for an integrated care facility.

Dr. Amanda Parsons also asked if there is any integration between the Access project and MetroPlus. Dr. Wilson indicated that there is a close working relationship between the two. Dr. Saperstein said that MetroPlus representatives schedule appointments as the patient is holding on the phone.

Strategic Planning Committee – December 10, 2013
As presented by Josephine Bolus, RN

Mr. Robert Nolan, Committee Member, introduced Mr. Joseph Quinones, Senior Assistant Vice President of Operations and invited him to provide an update to the Committee on HHC's outsourcing initiatives.

Mr. Quinones greeted Committee Members and invited guests. He stated that his presentation was a follow-up to a prior report that he made to the Strategic Planning Committee in March 2013 on HHC's outsourcing initiatives which included the Sodexo Dietary Operations, Crothall Environmental Services Operations, Sodexo Laundry Operations, Johnson Controls Plant Maintenance, and Atlantic Dialysis Operations. He reported that HHC's Finance Department had compiled an analysis to look at the savings that the Corporation had inured from these initiatives. Mr. Quinones informed the Committee that representatives from Sodexo, Crothall and Johnson Controls were present at the meeting to respond to any questions.

Dietary Operations Update

Mr. Quinones began his presentation by providing the Committee with an update on HHC's dietary initiative. Mr. Quinones reported that, in 2005, HHC had executed a contract with Sodexo Dietary Division, US Foods, and Nexera (the Consortium). The contract was fully implemented in early 2006 for a term of 10 years, with three five year renewal options.

Mr. Quinones described the objectives of the dietary initiative including achievements to date, vendor performance, and patient satisfaction. This description is summarized below:

Objectives of Dietary Initiative

- Improve patient care, quality of food and standardize menus (within first year of the contract)
- Increase patient satisfaction (to be monitored by independent survey every year after full implementation)
- Reduce corporate-wide meal cost (year one of the contract)
- Re-tool the Cook Chill Plant by replacing non-working equipment and using plant to its full capacity

- Standardize food policy and procedures throughout the Corporation
- Increase staff productivity

Achievements of Dietary Initiative

- Reduced staffing levels from 1,400 FTE's to current level of 963 FTE's
- Instituted corporate-wide formulary in 2008 for nutritional supplements that resulted in improved patient care and lowered costs
- Implemented a 21-day menu cycle for all acute care and long term care facilities in early 2006
- Improved patient satisfaction scores and sustained improvement every year
- Staffing assessment identified workflows that improved direct and indirect patient care and resulted in maximizing efficiencies since early 2006
- Standardized policies and procedures for food delivery, floor stock, supplements, nourishments, and catering in 2005
- Standardized reporting systems for cost controls and financial analysis resulting in real time information that allowed for rapid management corrective action plans since 2006
- Completed renovation of Cook Chill Plant in late 2005, producing 19K meals/day, 7 million meals/year, and adding capacity for generating potential revenue

Vendor Performance

- Each facility has assigned a contract liaison to whom the vendor reports
- The vendor produces reports on a monthly basis to the facility and HHC's Office of Operations tracks the vendor's contractual obligation such as staffing, contract expectations, and survey readiness.
- The vendor and facility staff conduct quality assurance audits to assure compliance with Center for Medicare and Medicaid Services' (CMS), Joint Commission on Accreditation of Healthcare Organizations' (JCAHO), and Department of Health's (DOH) guidelines as directed by each facility
- Mock surveys are also conducted by the vendor, Central Office and an independent consultant at least one year prior to an anticipated survey. All results are shared with the senior staff of each facility.

Measuring Patient Satisfaction

- The Corporation entered into an agreement with International Point of Contact (IPC), an independent company specializing in conducting surveys.
- HHC and IPC developed a survey tool made up of 17 questions and consistent with survey standards in order to measure the patient experience in a comprehensive way.
- The sample size was statistically validated by the vendor and totaled approximately 800 patients surveyed face-to-face.
- A baseline face-to-face patient survey was conducted prior to the Sodexo conversion to the Cook Chill Model in 2006.
- The survey has been conducted each year since 2007 and the results are compared year over year and to the baseline year.

Mr. Quinones reported that the results of the Patient Satisfaction Survey for FY 2013 for both acute and long term care (LTC) facilities from 2005 to 2013 (Wave I to Wave VIII of the initiative) are all above satisfactory with an overall mean score of 3.7.

Mr. Quinones reported on the savings analysis on a cash basis. He stated that they were actual savings of $43.1 million from FY 2006 through FY 2013 which is an average annual savings of $5.4 million. Mr. Quinones noted that, while the average annual savings may look below the target annual savings of $10 million, it should be taken into consideration that FY 2013 savings alone was $14 million. In addition, Mr. Quinones noted that there was an 18-month ramp up period and the attrition of almost 400 FTEs took three to four years to be completed. Mr. Quinones highlighted that there were 17 years left on this contract. He explained that, if $14 million in savings is achieved annually over the next 17 years, this would produce more than $11 million in savings on an annual basis over the cost of the entire contract. He reminded the Committee that the Sodexo Dietary contract is a 25-year contract and that the savings expectation was within a range of $10 million per year, not the year to year analysis as noted on the other initiatives.

At the request of Michael Stocker, M.D., Chairman of the Board, Mr. Quinones invited representatives from Sodexo to join him in presenting the update to the Committee. He was joined by Mr. Miles Foley, Vice President, and Josh Wilson, Senior Finance Manager of Sodexo. Dr. Stocker commented that this contract had drawn a lot of attention throughout the Corporation. He highlighted that there were two reoccurring issues. One issue is that improvement and satisfaction in the long term care facilities are less than the acute care facilities. Mr. Stocker noted that patients in the acute care facilities were not as sensitive to the variety of food as they are only admitted to the hospital for only a few days. However, at the long term facilities, Coler and Henry J. Carter, there have been a lot of discussion about the lack of variety of food throughout the 21-day menu cycle. The second issue is that the food is not hot. Mr. Quinones responded that, at the onset of this initiative, there were questions about whether or not this initiative would be successful at the long term care facilities. Mr. Quinones stated that he has had to live in a long term care facility to ensure that this model assured that food would be delivered to the patient hot. Mr. Quinones explained that the food is in a chiller and that the cart is rolled from the chiller. There is a buzzer that goes off and the cart is taken to the point of delivery. He explained that it was very difficult for him to understand what type of circumstance, on a recurring basis, that would alter this model and inhibit the delivery of food that is to delivered hot and food that is to be delivered cold. Mr. Foley added that they have very little control over the time that food is directly delivered to the behavioral health population, as Sodexo does not deliver food to this population. Mr. Foley informed the Committee that the variety of food in the long term care environment had been addressed for the residents through special initiatives they have

launched called "spirit lifters." He added that the neighborhood feeding environment at Henry J. Carter at Gouverneur is expected to impact the issue of the variety of food even to a greater extent.

At the request of Dr. Stocker, Mr. Foley explained the chiller process cycle. He explained that chillers use conduction heat where the heat is applied from a plate from underneath and it is convection cold inside the cart. Thus, it is a refrigerator and oven all in one. Mr. Foley explained that all foods are produced at a plant in Brooklyn. The food is then frozen and chilled and sent out overnight to all the facilities. At the facilities, the food gets plated and put into these carts and then re-therm accordingly to the delivery schedule. With the exception of DSSM where food is decentralized on each floor, the food is centrally re-therm and then brought up to the floor for immediate distribution to patients by dietary aides in a non-behavioral health environment. Once on the floor, Mr. Foley explained that Sodexo's standard is to ensure that the food is delivered to the units within 15 minutes. He noted that in the behavioral health environment, the nursing department is in charge of delivering meals to patients.

Dr. Stocker noted that the patient satisfaction survey scores are slightly up in the long term care facilities. Mr. Quinones stated that he had reviewed those numbers with Ms. Rhoda Brooks, President of IPC. He stated that it was discussed that those results were not statistically significant changes.

Mr. Nolan noted that the results of the Patient Satisfaction Survey for 2011-2013 were flat compared to 2006-2007 and slightly over satisfactory. He asked why the satisfactory score was acceptable and the target score raised above satisfactory to a 4.5 or 4.7. Mr. Aviles agreed with Mr. Nolan and stated that unquestionably there is always room for improvement. Referring to the baseline numbers in the long term care facilities, Mr. Aviles explained that the reason why these numbers were lower than the acute care side was because it was more challenging in the long term care environment as residents are more focused on the food since food is the bigger part of their day. Mr. Aviles stressed that there were some limitations in terms of what could be done with food to customize it to the taste of the 2000 patient population at Coler/Goldwater within a narrow time frame. Nevertheless, Mr. Aviles added that Sodexo had been very responsive and dietary and nutritional standards were also being followed. He noted that it is a continuing process and that adjustments are being made to try to introduce some additional entrees that are reflective of the diversity of the patient population.

Mr. Quinones added that, while the goal is to always strive for higher scores, two things should be taken into consideration when looking at these scores: 1) a continental breakfast is served; and 2) the Mayor's food guidelines have been met. Mr. Quinones explained that even though some improvements are needed in a couple of areas, overall, the Mayor's guidelines have been met. Mr. Quinones emphasized that these guidelines are very strict. He noted that the meals are virtually cooked with no sodium and sugar. Therefore, given those challenges, the initiative is proud of its ability to maintain the satisfactory scores.

Mr. Nolan referred to the $14 Million savings in 2013 and asked Mr. Quinones if he is projecting a yearly savings of $14 Million for the remaining years. Mr. Quinones stated that he was only making and observation and that Ms. Krista Olson, HHC's Deputy Budget Director is the only one capable of making these kinds of projections. Ms. Olson clarified that Mr. Quinones was reporting actual savings for FY 2013. She noted that the $14.6 million amount was adjusted slightly because of Hurricane Sandy. She added that it is uncertain at this stage whether this savings amount would go up or down. However, given the continued FTE level, it is expected that that level of savings to continue since it is the vast majority of the cost.

Mr. Bernard Rosen, Committee Member, asked about the projected savings for the 25 years. Mr. Quinones answered that this information is noted on the last slide of his presentation. Mr. Aviles answered that a yearly savings of $10 million was projected; thus, $250 Million for 25 years.

Environmental Services Operations Update

Mr. Quinones invited representatives of Crothall, Inc. to join him for the presentation. These representatives included Ken Vlass, Senior Regional Manager, and Michael Villani, Vice President, Northeast Region. Mr. Quinones reported that, in November 2011, HHC had executed a contract with Crothall, Inc. The contract was fully implemented in early December 2011. The contract's term is for a period of nine years.

Mr. Quinones described the objectives of HHC's environmental services initiative including achievements to date, vendor performance, and patient satisfaction. This description is summarized below:

Objectives of the Environmental Services Initiative

- Assure regulatory survey readiness of facilities 24/7
- Increase worker productivity (by year one of the contract)
- Increase Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) scores for all facilities
- Standardize workflow (within six months)
- Lower overtime costs (within six months)
- Obtain capital equipment from vendor at no cost to Corporation
- Training program for union staff
- No Union Layoffs

Achievements of the Environmental Services Initiative

- Environmental services operations retrained and absorbed 156 workers from the Brooklyn Central Laundry and facility laundry distribution workers throughout first year of contract.
- Attrition objectives have been achieved. 300 FTE have been attrited to date.
- Capital equipment totaling $1.3M has been delivered to EVS at HHC facilities at no cost to the Corporation - completed September 2012.
- All workflows at all facilities have been standardized and worker productivity has increased - completed January 2012.
- Total savings for year one and two of the contract were $16M, exceeding target savings on a cash basis by $3M.
- Crothall has absorbed and will be cleaning by February 2014 148,433 square feet of additional HHC space and 153,777 square feet of repurposed space. Financial impact is currently being reviewed by Finance and Operations.
- No Union workers were laid off.

Vendor Performance

- Each facility has assigned a contract liaison to whom the vendor reports.
- The vendor produces reports on a monthly basis to the facility and HHC's Office of Operations that tracks the Vendor's contractual obligations such as staffing, contract expectations, and survey readiness.
- The vendor and facility staff do "floor rounding" inspecting the areas of the hospital to assure compliance with Centers for Medicare & Medicaid Services (CMS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and Department of Health (DOH) guidelines.
- Mock surveys are conducted by the vendor, Central Office and an independent consultant prior to an anticipated Survey. All results are shared with the senior staff of the facility.
- Vendor performance during hurricane Sandy was exceptional. Crothall played a major role in restoring HHC impacted facilities, and assuring HHC met its schedule to reopen its hospitals to the community.

Mr. Quinones reported on the Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS). He reminded the Committee that the Corporation's goal has been to increase the HCAHPS scores. Mr. Quinones noted that Crothall has committed some at-risk dollars if target was not reached by year 2 of the contract. He pointed out on the chart that tremendous progress has been made as Year 2 of the survey data shows that the HCAHPS scores had improved at all the facilities and even exceeded the baseline by 6.2%.

Mr. Quinones reported that the actual savings over the first two fiscal years of the contract was $16.8 Million which exceeds the target savings of $13.2 Million by $3.6 Million.

Dr. Stocker acknowledged and thanked Crothall for its outstanding work during Hurricane Sandy.

Dr. Stocker queried Crothall's representatives for an overview of the Environmental Services Operations Contract. Mr. Vlass answered that there were some serious growing pains in the contract's first year. However, in the contract's second year, Crothall is beginning to settle in by understanding the culture of each facility and the staff understanding Crothall as a corporation. Mr. Vlass pointed out that the improvements of the HCAHPS scores are a testament that the collaboration between staff and management starts to take hold.

Dr. Stocker asked about the status of the 38 HHC Managers that were transferred over to Crothall at the beginning of the contract. Mr. Vlass said only one of them remains with the company. Mr. Vlass explained that many of these individuals either resigned on their own or were terminated because of their unsatisfactory performance. Dr. Stocker asked if these managers were replaced by HHC staff or internally. Mr. Vlass answered that they were replaced by Crothall employees. Dr. Stocker observed that it was a big change of personnel. Mr. Vlass stated that they have also experienced recurring turnover as they are constantly looking for the right management team to fit the organization as a whole and more importantly the culture of each facility. Mr. Villani emphasized that all changes in personnel have been communicated with Mr. Quinones and his staff, Mr. William Brand, Director of Procurement Systems, as well as the onsite facilitators and the staff. He added that a good communication line is kept at all levels to ensure that all parties understand why the changes were made and what the benefits are.

Mr. Quinones interjected that every termination of the Managers was brought to his attention to ensure that it was necessary and handled properly.

Dr. Stocker asked about Crothall's relationship with the union workers. Mr. Villani answered that they have an ongoing open communication relationship. He added that, while there are issues around accountability and change in expectations, Crothall has been doing its best to communicate with the union workers, their representatives, as well as their front line staff. He noted that other issues that frequently come up are: 1) supplies, as adjustments were made to the way they have been distributed to the facility prior to Crothall's contract; 2) workload, including rollout of change of duties and change of responsibilities. Mr. Villani stated that issues do arise and are all dealt with both on the front line level and the supportive representation from the union staff.

Mr. Quinones was asked to address the supplies issue that came up at the Annual Public Meetings as it would continue to come up. Mr. Quinones informed the Committee that one of the goals of the Environmental Services Operations contract is to ensure that the par levels are kept where they should be at each one of the facilities. He noted that these par levels have been dramatically reduced operating on a "Just in

Time" schedule. He emphasized that only the needed supplies are at hand on a week-to–week basis, not a whole storehouse of supplies are stored.

Mr. Vlass added that they have the ability to order every day and have it delivered the same day if need be.

Dr. Stocker observed that the HCHAPs scores aggregate numbers by 1% just over a six-month period. He asked if the 68% target for Year 2 was set at the beginning before the contract started. Mr. Vlass and Mr. Villani answered positively. Dr. Stocker asked if they would be able to exceed the 68% target. Mr. Vlass referred to the chart and answered that NCB and Queens have already exceeded the target. He added that exceeding the 68% target was possible because of staff engagement and awareness of the importance of the HCAHPs scores at the facilities. He added that the combination of the right management team and staff engagement, the HCAHPS scores will undoubtedly be raised.

Mr. Quinones interjected that the goal is to have a strategic approach that is patient centered, patient focused, ensuring that concentration is put on the areas with the lower HCAHPS scores. Mr. Villani added that Crothall is confident to reach the target. A number of steps were taken after Hurricane Sandy to recover due to a lot of changes from the storm and the influx of patients at the facilities that were open. Mr. Villani reported that overall, Crothall had to recover from a three-month slide. He noted that, overall the system took a hit as far as satisfactory in environment and all aspects of patient satisfactory. Mr. Villani informed the Committee that, while Crothall's contract included only one system Patient Experience Manager for all 11 facilities, since then, an additional Patient Experience Manager has been added, at the company's own expense, to work with the four facilities with the lower scores and help drive those scores to reach or even exceed the Year 2 Target.

He added that more resources were added to ensure that the scores are raised. He informed the Committee that originally, Crothall's contract included only one system Patient Experience Manager for all 11 facilities. However, since then, at the company's expense, an additional patient experience manager has been added to work with the four facilities with the lower scores to help drive those scores and reach or even exceed the Year 2 target.

Dr. Stocker commented that HCHAPS scores are very crucial to patient satisfactory. Mr. Villani acquiesced and added that they are also the number one driver for Crothall's contract.

Ms. Andrea Cohen, who represents Deputy Mayor Linda Gibbs in a voting capacity, asked about Crothall's experience with any other health systems or customers whereas its management team is overseeing and managing a unionized workforce. Mr. Villani answered that nationally, 55% of their 500 accounts have this type of arrangement including 80% of the Northeast region accounts.

Ms. Cohen asked about Crothall's challenges in this transition compared to other systems. Mr. Villlani answered that the challenges were fairly typical in a sense of getting a system working as a system and standardizing practices across the system. He added that these challenges were similar to the ones encountered at all the other facilities. Mr. Villani stated that the Group 12 supervisors, or Teamsters, are a very important cog in Crothall's program in driving its system and programs and holding the hourly workers accountable and driving satisfaction and quality. In addition, the company had formalized training and orientation and a buy-in program. He noted, however, that there has been a lot of turnover in that position. Mr. Villani informed the Committee that starting in January 2014, Crothall's main objective is to work on a plan to re-educate, re-in-service and try to get their engagement to Crothall's programs as the Teamsters are vital to Crothall's success and evolvement.

Ms. Brown asked about Crothall's staff engagement assessment. She would like to know if Crothall's staff engagement assessment for training, in particular, include surveys or exit conferences. Mr. Villani answered that Crothall's orientation program is keyed on Crothall's systems and programs and the culture of the company adapted to the client's culture and system. As part of an ongoing process, the two are joined together and oriented not only to Crothall's expectations, but also to the client's expectations. In addition, formal and informal in-service processes include: bi-annual training to daily huddles, weekly in-service training both on an operational standpoint and safety standpoint. Moreover, daily huddles are held with staff open forums as well as weekly staff meetings. Mr. Villani noted that a performance-based formal reward recognition program is also included among the many initiatives.

In addition to staff engagement, Ms. Brown would like to know if Crothall also assess staff satisfaction periodically. Mr. Vlass answered that the staff is periodically assessed on their level of satisfaction. He added that there is a base line and a re-assessment of the baseline is done yearly.

Mr. Nolan asked about the attrition level. He observed that in less than 2 years, 300 FTE"s have left the payroll. He asked why such a significant number of employees have left the payroll. Mr. Quinones answered that, as noted in his next update on the laundry initiative, over 150 FTEs were deployed into environmental services. He clarified for Mr. Nolan that these employees are included in the 300. Ms. Olson added that while attrition in general runs about 6% or 7% it is higher in housekeeping as typically, the lower paying jobs attrite at a much higher rate.

Dr. Stocker asked if employees are given the opportunity to work in different departments and move up the company's ladder. Mr. Vlass and Mr. Villani answered positively.

Laundry Operations Update

Mr. Quinones invited representatives of Sodexo and Nexera to join him for the presentation of HHC's laundry initiative. These representatives included Courtney Marcin, Nexera Consultant, and Miles Foley, Vice President of Sodexo. Mr. Quinones informed the Committee that HHC had executed a contract with Sodexo's Laundry Division and Nexera Inc., (the Consortium) in July 2011. The contract was fully implemented in November 2011. The term of the contract is for a period of nine years.

Mr. Quinones described the objectives of HHC's laundry operations initiative including achievements to date, vendor performance, patient satisfaction, and additional identified savings. This description is summarized below:

Objectives of the Laundry Operations Initiative

- Close Brooklyn Central Laundry and re-deploy staff by October 2011
- Lower cost for supplies and linen processing
- Lower personnel services cost for laundry distribution
- Standardize HHC Laundry Operations Policies & Procedures
- No union layoffs

Achievements of the Laundry Operations Initiative

- Completed 90-day transition of linen distribution and processing on schedule by the end of October 2011
- Redeployed 156 full-time HHC employees out of Linen & Laundry Operations to Environmental Services
- Closed Brooklyn Central Laundry (BCL) on schedule in October 2011
- Standardized policies and procedures for linen and laundry operations by the end of October 2011
- Implemented linen management web-based tool to track linen utilization in December 2011

*Vendor Performance (*As noted below, the vendor's performance is monitored through the same steps identified in the previous initiatives)

- Each facility has assigned a contract liaison to whom the vendor reports.
- The vendor produces reports on a monthly basis to the facility and HHC's Office of Operations that tracks the vendor's contractual obligation such as staffing, contract expectations, and survey readiness.
- The vendor does facility "floor rounding" inspecting the areas of the Hospital to assure compliance with Centers for Medicare & Medicaid Services (CMS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and Department of Health (DOH) requirements as required by each facility with Administrators of the facility.
- Mock surveys are conducted by vendor, Central Office and an independent consultant prior to an anticipated survey. All results are sent to senior staff at the facilities.
- Mock surveys are also conducted by an independent consultant at least one year prior to an anticipated survey. All results are shared with the senior staff of the facilities.

Mr. Quinones reported on the Patient Satisfaction Survey for FY 2012. He noted that the facilities have dramatically increased their scores for the whiteness and softness of the linen.

Additional Savings Identified

Mr. Quinones reported that HHC had identified additional savings opportunities. These savings opportunities include:

- Transition of six facility internal laundries to Sodexo:
    - Total pounds processed by the internal laundries was 1.3 million additional pounds of linen
    - 24 additional FTE's were transferred out of laundry operation to other departments within the facility

- Transition of six residential clothing:
    - A total of 640,000 lbs. of residential clothing are being processed with 26.8 FTE's identified to be transferred to other HHC departments within the facility

- Efforts to reduce linen losses. Linen losses are substantially higher than projected and will have a financial impact on the contract. Once analyzed, Operations and Finance will issue a report identifying those costs and actual savings. Sodexo and HHC have instituted a linen-loss program throughout HHC facilities.

Mr. Quinones reported that the target savings for the first two years of the contract implementation was $13.5 Million. He noted that over the first two fiscal years, HHC has achieved savings of $9.2 Million in laundry services. While the savings are lower than projected, the contract is right on track. It is to be noted that there will be additional savings derived from the additional residential clothing and internal laundries as there were no FTEs added to this contract. He stressed that the FTEs will come up as savings for HHC.

Dr. Stocker asked Mr. Foley to comment about the relationship between Sodexo's Laundry Operations and the Corporation. Mr. Foley answered that because Sodexo had the benefit of the food contract and was more matriculated into the environment, they did not have the

growing pain they initially had with the dietary initiative. He added that Sodexo's plan of operations was understand what the numbers were in Year 1 and overcome some data issues. He underscored that they were able to take on additional poundage with 2 ½ FTEs under the original budget.

Dr. Stocker asked about the composition of the Laundry Operations staff. Mr. Foley answered that the management team is fully operated by Sodexo staff and that the production is outsourced to Unitex, whose plant is located in Mount Vernon. He noted that it is a complete different model than the one run by HHC.

Dr. Stocker asked if Laundry Operations personnel are given the opportunity to move up within the organization. Mr. Foley answered positively. He added that quite a few managers have already been promoted to the inventory control manager positions at the facilities. In addition, Mr. Foley stated that Sodexo has a very robust training development program and Sodexo University, an accredited university. Mr. Foley referred to LaRay's question about staff engagement and stated that Sodexo staff engagement process includes an engagement survey which is reported yearly on their website, sodexo.net. In addition, Mr. Foley stated that there is constant communication with staff for front line leadership training and development not only where they are employed in dietary or housekeeping, but also cross-trained from dietary to housekeeping and vice versa.

Mr. Nolan asked about Sodexo's plan in the next two years to boost up HHC's savings.

Mr. Foley answered that Sodexo will first review the linen losses and put in place the linen management system and identify the facilities which have a higher incidence of linen losses. In addition, Sodexo will work with facility staff to identify how to properly handle the labels and get the linen back to Sodexo and try to minimize the intentional and unintentional hoarding of linen.

Plant Maintenance Operations Update

Mr. Quinones invited the representative of Johnson Controls, Inc., (JCI), Mr. Nick Lanci, Operational Director to join him in presenting an update on HHC's Plant Maintenance Operations initiative. Mr. Quinones informed the Committee that HHC had executed a contract with Johnson Controls, Inc., in July 2012. The contract term is for a period of nine years.

Mr. Quinones described the objectives of HHC's Plant Maintenance initiative including achievements to date and vendor performance. Mr. Quinones' update on the JCI contract's first year is summarized below:

Objectives of Plant Maintenance Initiative

- All facilities have a work order system that drives the purchase requisitions and schedules routine plant maintenance testing.
- All employees participate in safety training seminars
- Standardize workflow for plant maintenance routine programs
- Achieved savings of $900,000
- Major assessment of useful life completed on plant infrastructure
- Quick access to needed expertise and equipment in response to emergencies
- Standardization of regulatory documentation for all facilities meeting code requirements
- Quick turnaround on procurement of needed plant maintenance materials
- Standardization of enterprise-wide service maintenance contracts

Measuring Vendor Performance

- Each facility has assigned a contract liaison to whom the vendor reports.
- The vendor produces reports on a monthly basis to the facility and HHC's Office of Facilities Development (OFD).
- Central Office OFD has an assigned team that works with the facility managers and JCI operations staff to track ongoing issues and insure contract guarantees are met.
- In order to insure survey readiness, both JCI and Central Office perform mock surveys and forward the results to Central Office and the facility executive administration.
- Enterprise wide surveys are distributed to the Senior Vice Presidents and Executive Directors to analyze JCI performance levels at each facility.
- Quarterly meetings with JCI Executive leadership are held with HHC's Chief Executive Operations Officer to discuss areas of success and failure in the implementation of the contract.
- JCI has absorbed and will be maintaining additional assets at certain facilities due to certain capital projects that have expanded facility assets. Financial impact is currently being reviewed by Finance and Operations.
- Vendor performance during Hurricane Sandy was exceptional. JCI played a major role in restoring HHC impacted facilities, and assuring HHC met its schedule to reopen its hospitals to the community

Mr. Quinones reported that actual savings after the first year of implementation was $900,000, $400,000 less than JCI's first year target savings of $1.3 Million.

Dr. Stocker asked Mr. Lanci to comment on JCI's relationship with HHC. Mr. Lanci answered that JCI's contract started out with 32 Directors and Assistant directors, 80% of whom were taken over from HHC. He added that all the 32 are still employed by JCI, except for one. Mr. Lanci informed the Committee that over the 18 months period of the contract, there have been only 3 terminations, one of which was a former HHC employee. Mr. Lanci noted that the attrition rate has been good in terms of management from JCI. Mr. Lanci stated that, while the turnover rate among the prevailing wage earners has been very low, there has been a targeted attrition plan to bring the total number down. Mr. Lanci reported that JCI has been weve been successful in achieving the target number for the first year and is close to the second year target number.

Mr. Lanci reported on JCI's employee relations. Mr. Lanci stated that each facility may have between 8 and 11 different unions, thereby different contracts. He noted that the directors and managers have a lot of work to do to manage different contracts. He reported that to date there has not been any major grievance from the unions for work violations or unfair practices for JCI/HHC towards the union. He added that the only complaint is that the unions would like to see more workers on their work rosters. Mr. Lanci underscored that JCI has done very well in maintaining labor relations.

Mr. Aviles interjected and informed the Committee that Mr. Lanci himself is a former HHC Director of Facilities Management to HHC facilities.

Dr. Stocker asked Mr. Lanci about his tenure at HHC. Mr. Lanci answered that he had worked at HHC for 17 years. Dr. Stocker also asked Mr. Lanci about potential for advancement at JCI. Mr. Lanci answered that JCI employees can take advantage of two career paths. The first opportunity is for the Assistant Directors to be promoted to Directors. The second career path is an opportunity for all JCI managers to apply for higher career levels. These managers can apply for training to enhance their skills. Mr. Lanci informed the Committee that JCI tries to run as many management seminars and training programs as possible either internally or outside the company.

As for the prevailing wage trades, Mr. Lanci noted that there is a civil service career path. However, if they choose to leave the civil service path, they have the opportunity to transfer to JCI and become managers. Mr. Lanci reported that there has been one successful promotion so far of a civil service employee to a JCI Manager. He added that it sets the tone for other trade employees to take advantage of the promotional opportunities at JCI.

Ms. Cohen asked about the metrics that JCI will use to survey to measure its performance as its services are not associated with an HCHAPS question. Ms. Cohen asked if, perhaps, timeliness could be a key factor. Mr. Quinones answered that timeliness is measured on a continuous basis as it relates to work order completion. He added that if something needs to be repaired at the facility, the question is how much time is needed to get it repaired or was it repaired within the scheduled maintenance and lastly to ensure that preventive maintenance of all HHC's assets are carried out in a timely manner. Therefore, the issue of timeliness is very precise and very technical.

Mr. Lanci added that JCI measures the core metrics in three major areas on a daily basis: 1) work order completion and work order generation by many sources. 2) preventive maintenance (PM) performance that are pre-loaded to the computerized metrics management system. The performance of the facility in terms of completing those PMs in a time allocated. A monthly report is submitted monthly to the facility and to HHC. 3) regulatory compliance. It includes mandatory activities such as environmental care, EPA, DEC, etc.

Mr. Quinones reminded the committee that Hurricane Sandy hit when JCI was only 90 days into the contract. He added that JCI has played a major role in restoring services at the affected facilities. Mr. Quinones also stressed that hurricane Sandy has caused interruptions all the way through March 2013. Therefore the $900,000 savings should not be looked at in isolation without taking that into account.

Mr. Antonio Martin, Executive Vice President, added that JCI was very instrumental in the opening of the Henry J. Carter Skilled Nursing Facility. In addition, Mr. Martin reiterated that JCI's services were invaluable around Hurricane Sandy. Mr. Martin informed the Committee that he regularly meets with JCI's leadership quarterly and the Senior Vice presidents. Mr. Martin stated that it is very important that JCI and HHC are closely aligned to ensure delivery at the facilities.

Dr. Stocker sympathized with JCI for having suffered the impact of Hurricane Sandy in the first 3 months of the contract as multiple hospitals were disabled. Dr. Stocker thanked Mr. Lanci and the JCI team for a job well done.

Dialysis Transition Update

Mr. Quinones provided the Committee with an update on the Dialysis transition initiative. He reported that the contract with Atlantic Dialysis Management Services was executed in February 2013. He informed the Committee that the following facilities have been transitioned to Atlantic Dialysis:

- Woodhull Medical and Mental Health Center — March 2013
- Queens Hospital Center — March 2013
- Coney Island Hospital — May 2013
- Jacobi Medical Center — September 2013
- North Central Bronx Hospital — November 2013
- Chronic facilities: Kings, Harlem, Lincoln, Metropolitan — 1st Quarter 2014

Mr. Quinones reported that Atlantic Dialysis has been able to facilitate discharge of approximately 100 inpatients. In addition, new dialysis equipment has been purchased for all acute units. He announced the proposed dates for the chronic dialysis to be transitioned to Atlantic Dialysis as noted below:

- Kings County Hospital — February 2014
- Harlem Hospital Center — March 2014
- Metropolitan Hospital Center — April 2014
- Lincoln Medical and Mental Health Center — Summer 2014
- North Central Bronx new facility — 2015

Mr. Quinones reported that a new unit will be constructed by the vendor at North Central Bronx Hospital (the estimated start of construction is in 2015). When all construction is fully completed, 57 more dialysis stations would have been added to the system. Mr. Quinones added that 31 HHC FTEs have been re-deployed to other existing vacant positions. He reported that current savings from January to October 2013 is $825,000.

Dr. Stocker commented that this new contract has brought a lot of attention and appears to be heading in the right direction. Mr. Quinones added that the contract is right on-schedule. Mr. Martin added that Atlantic Dialysis Management Services has effectively helped HHC to transition some of its long stay dialysis patients out of the acute care facilities, particularly at Jacobi Hospital Center. Mr. Martin reported that as many of these patients were just stocked there, Atlantic Dialysis staff were able to transition them to outpatient clinic dialysis.

Mr. Rosen asked about the Rive Renal Services contract. Mr. Quinones clarified that this contract for Dialysis services at Bellevue Hospital Center was a facility-driven initiative and was not part of the Road Ahead Outsourcing initiatives. He noted that to date, Bellevue Hospital has been very pleased with the vendor's performance. He informed the Committee that this initiative will be implemented at Elmhurst Hospital in the near future and that their new equipment has been ordered and on schedule.

Mr. Quinones concluded his presentation by reporting on the savings for all the outsourcing services:

- *Dietary*

Throughout the 8 years of the contract, $43.1 million savings achieved to date. The target contract savings for 15 years (three 5-year options remaining) was $150 Million.

- *Laundry*

Throughout the first 2 years of the contract, $9.2 million savings achieved to date. The target contract savings for 9 years was $58 million.

- *Environmental Services*

Throughout the first 2 years of the contract, $16.8 million savings achieved to date. The target contract savings for 9 years was $180 million.

- *Plant Maintenance Operations*

For the first year of the contract, $900,000 savings achieved to date. The target contract savings for 9 years was $127 million.

- *Dialysis*

For the first 10 months of the contract, $825,000 savings achieved to date. The target contract savings for 9 years was $147 million.

Mr. Quinones reported that, cash savings to date for the five initiatives are $70.8 million. After all contracts are executed, the expected total savings will be $662 million.

Mr. Rosen suggested that it would have been helpful to include the attrited positions in the Cash Analysis slide. Mr. Quinones agreed and stated that the slide will be revised to include them.
Mr. Nolan asked if the target contract savings are included in HHC's budget. Ms. Olson answered that they were included in the financial plan of the initial restructuring targets for the four-year plan. She cautioned that these targets were not at the initiative-specific level. However, upon looking at a specific initiative, whether it is over-achieved or under-achieved, that amount is included.

Mr. Aviles clarified that the $662M savings are a combination of optimized revenue and cost savings. However, he noted that a lot of the additional attritions unrelated to these have generated a good deal of the cost savings.

Mr. Nolan thanked Mr. Quinones for an excellent presentation. Dr. Stocker agreed and commented that the presentation should be sent to the Board for discussion.

SUBSIDIARY BOARD REPORTS

MetroPlus Health Plan, Inc. – December 10, 2013
As reported by Mr. Bernard Rosen

Chairperson's Remarks

Chair Rosen welcomed everyone to the final MetroPlus Board of Directors meeting for the year 2013. Immediately following the meeting the Annual Public meeting will be held.

Mr. Rosen introduced George Proctor, MetroPlus' newest Board member.

Mr. Rosen stated that the meeting would start with the Executive Director's report presented by Dr. Saperstein followed by the Medical Director's report presented by Dr. Dunn. In addition, there would be 8 resolutions for approval including one to adopt the annual operating budget for fiscal year 2014. The resolutions would be presented after the adoption of the minutes.

Mr. Rosen received approval to appoint members to the MetroPlus Executive Committee. The members appointed to serve on the Executive Committee were Dr. Arnold Saperstein, Meryl Weinberg, George Proctor, Dan Still and Bernard Rosen.

Mr. Rosen wished everyone a happy and healthy holiday season and all the best for the coming year.

Action Items:

The first resolution was introduced by Mr. Dan Still, Chairman of MetroPlus' Finance Committee and Audit and Compliance Committee.

Adopting the annual operating budget and expense authority of MetroPlus Health Plan, Inc. (the "Plan"), for Fiscal Year 2014.

Mr. Cuda reviewed in detail the highlights of the budget. Mr. Cuda provided the Board of Directors with a summary chart that compared the 2013 budget to the proposed 2014 budget. Mr. Still advised that this budget was discussed at length at the Finance Committee that took place in November. Mr. Martin asked Mr. Cuda to review the capital expense and Mr. Cuda stated that the majority of the expense was for the Business Resumption Plan.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors.

The second resolution was introduced by Mr. Still.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to increase the spending authority for the contract with McMurry/TMG, ("McMurry") dated October 1, 2012 and to allocate additional funds for the fulfillment of the contract, for a total amount not to exceed $650,000 per year for the term which expires on September 30, 2015 and has two options to renew for one year each.

Dr. Saperstein stated that this increase is needed to develop and create a newsletter for the exchange population.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors.

The third resolution was introduced by Mr. Still.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to negotiate and execute a contract with The Myers Group, to provide consumer satisfaction services for a term of three (3) years with two options to renew for a one (1) year term, each solely exercisable by MetroPlus, for a total amount not to exceed $1,470,000 for the entire five (5) year term.

Mr. Still stated that he noticed that The Myers Group was the only respondent. Dr. Dunn replied that it surprised him as well and that the RFP was well advertised and went out to several vendors. Dr. Dunn stated that the Plan has several years experience with The Myers Group and is very satisfied with their work. Mrs. Gail Smith, MetroPlus' Chief Customer Officer, stated that quite a few states use The Myers Group through the Health Plan Alliance that MetroPlus is a member of.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors.

The fourth resolution was also introduced by Mr. Still.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to increase the spending authority for the contract with OptumInsight, dated April 1, 2012, and to allocate additional funds for the fulfillment of the contract, with the total amount not to exceed $2,707,000 for the total term of the contract.

Mr. Rosen asked if this is a contract adjustment and Dr. Dunn replied yes. Dr. Dunn stated that the Plan uses OptumInsight to help with the Plan's HEDIS/QARR submissions to the State. The facilities now would like to see the data on a monthly basis and OptumInsight has the ability to allow the facilities to access their portal and get the information they need. Dr. Dunn stated that this will help keep the Plan competitive.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors.

The fifth resolution was introduced by Mr. John Cuda, MetroPlus' Chief Financial Officer.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to negotiate and execute a contract with Wakely Consulting Group, to provide Exchange consulting services for a term of one (1) year with two (2) one-year renewal options, solely exercisable by MetroPlus, for an amount not to exceed $3,000,000 for the total 3 years.

Mr. Cuda gave the Board a detailed overview of the services that the Plan needs Wakely to perform. Mr. Cuda advised the Board that the vendor was present. Mr. Martin asked the vendor if he could hear a little bit about their background. Mr. Jon Kingsdale, Director of Wakely Consulting Group's Boston office introduced himself to the Board. Mr. Kingsdale gave the Board a summary of Wakely's background and its experience with the State Exchange programs.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors.

The sixth resolution was introduced by Dr. Arnold Saperstein, MetroPlus' Executive Director.

Approving Tamira Boynes for nomination to serve as a member of the Board of Directors of MetroPlus Health Plan, Inc. ("MetroPlus"), to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors and will go to the HHC Board of Directors on December 19, 2013.

The seventh resolution was also introduced by Dr. Saperstein.

Approving Meryl Weinberg for nomination to serve as a member of the Board of Directors of MetroPlus Health Plan, Inc. ("MetroPlus"), to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors and will go to the HHC Board of Directors on December 19, 2013.

The eighth resolution was introduced by Mr. Stanley Glassman, MetroPlus' Chief Financial Officer.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to execute a lease between MetroPlus and 2221 Church Avenue LLC for approximately 2,000 square feet of space located on the first floor at 2221 Church Avenue, Borough of Kings to house sales and customer service facilities of MetroPlus for a term of ten years at a base rent of $51 per square foot, per year which shall increase at 3% every year over the lease term and which shall include the cost of building out the space to the building standard but will leave MetroPlus with a cost of approximately $175,000 for the installation of furniture and IT equipment.

Mr. Rosen asked if this was a storefront and where exactly it was located. Mr. Glassman stated that it is a storefront and it is located 4 stores off the corner of Flatbush and Church Ave in Brooklyn. Mr. Glassman said this location is a high foot traffic area and should allow MetroPlus to have a visible presence in the community. There was a brief discussion regarding HHC contracted real estate agents.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors.

Executive Director's Report

Before starting his report, Dr. Saperstein took a moment to thank Mr. Stanley Glassman for his service to MetroPlus for the last 5 ½ years. Dr. Saperstein stated that Mr. Glassman is moving on to a new endeavor and wished him good luck in the future.

Dr. Saperstein reported that total plan enrollment as of November 27th, 2013 was 419,080. Breakdown of plan enrollment by line of business is as follows:

Medicaid	357,056
Child Health Plus	12,086
Family Health Plus	33,390
MetroPlus Gold	3,286
Partnership in Care (HIV/SNP)	5,367
Medicare	7,465
MLTC	430

Dr. Saperstein stated that Plan membership has declined since his last report to the Board; MetroPlus lost 5,628 members since the last report in September. The Plan attributes this loss to a Human Resources Administration backlog of unprocessed applications, in addition to high rates of members losing Medicaid eligibility. MetroPlus anticipates a recovery of some of these losses in the coming months.

In an effort to increase presence in the community, MetroPlus is planning to lease two storefront spaces to service its current and potential membership. MetroPlus is planning to establish storefront offices in Queens and Brooklyn. At these new storefronts, the Plan will be able to enroll new members and assist existing members with recertification and other issues. It is expected that these offices will open in early 2014.

Dr. Saperstein reported that, on October 1st, the New York State Exchange went live, offering health insurance options on the NY State of Health, the Official Health Plan Marketplace. As of the last week in November, the State reported that about 275,000 people statewide had completed the full application for coverage and nearly 76,000 had enrolled in the NYS exchange. Of these, 35,000 were Medicaid and about 41,000 signed up for the participating plan. MetroPlus has received over 4,000 non-Medicaid enrollees from the Exchange. Of these, 47% are under age 35, and 73% are under age 50. MetroPlus has trained all of its Facilitated Enrollers to serve as Certified Application Counselors to aid eligible members with enrollment into the Exchange. As part of the Plan's entry into the Exchange, it is expanding its provider network to service the incoming membership. MetroPlus has contracted with St. John's Episcopal in Queens for all lines of business, and are in negotiations with other facilities to add them to the Plan's network for the Exchanges during 2014.

MetroPlus has also added Montefiore Medical Center in the Bronx to its network to service the Plan's Medicaid, Child Health Plus, Family Health Plus, MetroPlus Gold, HIV SNP, Medicare Advantage and FIDA populations. This contract does not include primary care, nor does it include MetroPlus Exchange members.

Dr. Saperstein stated that, this month, the Plan has continued to make strides with MetroPlus' business resumption plan. MetroPlus has leased space in the Bronx on Eastchester Road to serve as the Plan's location to resume operations. This space will house approximately 325 permanent seats and conference space for key departments. MetroPlus also has available 210 leased seats at SunGard in Long Island City. Also, in November, the Plan presented results of its in-depth internal audit of its business resumption plan at the MetroPlus Audit and Compliance Committee meeting. There were findings of areas that needed improvement and MetroPlus has already begun to address the areas of concern.

Medical Director's Report

Dr. Dunn stated that, as part of MetroPlus Health Plan's continuing efforts to provide health education and valuable information to its members, the Plan completed several different mailings. A mailing reminder was sent out to all women aged 16-24 years to remind them to have at least one test for Chlamydia during the year. An educational postcard was sent to all members who were considered high risk and needed to get a flu shot and/or pneumonia vaccine. The eligible members include all members in the HIV/SNP plan, or those who are 65 and older, or those who have asthma or diabetes between the ages of 58 and 64, or those who are under 18 who had an emergency room visit or inpatient admission for asthma or diabetes. In an effort to educate members about the importance of taking care of their diabetes, a diabetes readmission letter went to providers and member advising of any member that who was admitted or re-admission to a hospital so that the member and provider can focus on the importance of outpatient care. All HHC facilities received their facility specific member satisfaction results, which were collected using the Consumer Assessment of Healthcare Providers and Systems survey. This is the same survey that the NYS Department of Health uses to assess health plans patient satisfaction. And lastly, a reminder flyer was mailed to all Medicare members over the age of 65 about physical activity and how to prevent falls in the home.

Dr. Dunn reported that MetroPlus developed a new Pay for Performance (P4P) program that is based on HEDIS/QARR measures. This program replaced the old Medical Performance Pool Distribution Program and Chronic Disease P4P program. All HHC facilities and community providers with 200 or more members are eligible to receive reward dollars through the P4P program. A provider receives money for a measure if they exceed the MetroPlus average, or the statewide Medicaid average, or their own rate on their prior report by a statistically significant difference. The amount of dollars rewarded for each measure is noted on the report. For first quarter 2013, MetroPlus awarded $5 million in quality incentive through the P4P. Elmhurst Hospital Center was the top hospital performer with a $561,000 quality incentive award. International Pediatrics Plus was the top community provider with a $26,000 quality incentive award.

The Quality Management Department is working on a performance improvement project to ensure quality health care to MetroPlus members with diabetes. One of the chief interventions is a member incentive. The Plan is in the process of developing a strategy to reach out to MetroPlus members to enroll them in diabetes prevention programs. The plan will use a two pronged approach of inviting members through the mail and followed up by a phone call.

Dr. Dunn stated that the second quarter 2013 Clinical Risk Group (CRG) Reports were distributed to all HHC facilities. In addition, some of the sites requested non-user lists to conduct outreach to get members into care. The current second quarter 2013 report shows disappointing trends. The non-user rate has been increasing at each HHC site. In terms of CRGs and HEDIS scores, getting non-users back into care is critical.

As of October 1, 2013, mainstream Medicaid managed care and HIV Special Needs began covering hospice services. Hospice is a coordinated program of home and/or inpatient non-curative medical and support services for terminally ill persons and their families. The program is available to persons with a medical diagnosis of one-year or less to live. For one-year, managed care plans must pay the Medicaid Fee-for-Service per diem rate for members receiving Hospice services.

Dr. Dunn reported that, effective March 1, 2014; all Medicaid recipients over age 21, in need of custodial care will be required to join a Medicaid managed care plan or a Managed Long Term Care Plan. All current custodial care recipients in a skilled nursing facility prior to March 1, 2014 will remain fee-for-service and will not be required to enroll in a managed care plan. Six months after the implementation (September 1, 2014), the State will allow any individual in a nursing home prior to March 1, 2014 to enroll in a managed care plan on a voluntary basis. For a two-year period, managed care plans must pay the Medicaid Fee-For Service per diem rates for members receiving custodial care in a skilled nursing facility.

Dr. Dunn announced that December 1, 2013 was World AIDS Day. In the 25 years that have passed since the first annual commemoration of World AIDS Day, extraordinary scientific progress has been made in the fight against HIV/AIDS. That progress has turned an HIV diagnosis from an almost-certain death sentence to what is now for many, a manageable medical condition and nearly normal lifespan. The Partnership in Care program works tirelessly to engage and encourage members to maintain an ongoing relationship with their primary care provider, and to regularly take their medications as instructed. Partnership in Care Program can help people living with HIV/AIDS stay healthier and get the care they need.

HHC Capital Corporation – November 21, 2013
As reported by Dr. Michael Stocker

Equipment Financing Program
Ms. Dehart mentioned that in July 2013, the HHC Board of Directors approved a resolution authorizing the CFO to initiate steps toward securing equipment financing of up to $40 million. HHC has been working with its financial advisor (PFM) and bond counsel (Hawkins Delafield & Wood, or HDW) to identify a pool of potential lenders active in the Northeast region. The short list of banks with credit ratings of at least "A" that have expressed interest in lending to HHC are: Bank of America, BB&T Equipment Finance, Chase Equipment/JP Morgan, PNC, RBS Citizens, TD Bank, U.S. Bank and Wells Fargo. Once an equipment list is available, the entire financing process is expected to last 6 weeks. Debt Finance is currently working with PFM and HDW to produce a draft financing document with generic terms for initial distribution to potential lenders.

Construction Fund Balance on the 2010 Bonds
Ms. Dehart provided the construction fund balance on HHC's Series 2010 bonds. Of the approximate $200 million, $35.2 million remains unspent as of October 15, 2013. Recently, Debt Finance worked closely with HHC's Office of Facilities Development to update the encumbrances which amounts to $187.4 million. The funds were used to purchase equipment, the Epic electronic health record and to finance construction projects throughout the Corporation.

In response to Ms. Youssouf's question about the timing of expending the bond proceeds, Ms. Lok stated that HHC is required to spend down the construction fund balance within 5 years.

HHC Health System Bonds – Arbitrage Rebate
Ms. Lok explained that bond issuers routinely incur arbitrage if the interest earnings on bond proceeds exceed the bonds' yield. In those instances, the arbitrage rebate liability must be rebated to the IRS. During October and November 2013, HHC's rebate consultant (Hawkins Delafield & Wood) prepared and filed Arbitrage Rebate Form 8038-T for the 2008 Series A and 2008 Series B - E bonds after determining that no rebate was due.

Bond Counsel Selection Process
In July 2013, Debt Finance issued an RFP for Bond Counsel services. In August, proposals were submitted by four firms: Harris Beach PLLC, Hawkins Delafield & Wood LLP, Nixon Peabody LLP and Winston Strawn LLP. Ms. Mar said that the evaluation committee consisting of representatives from the NYC Comptroller's Office, the NYC Office of Management and Budget, Bellevue Hospital, HHC's Office of Legal Affairs and HHC Corporate Finance selected HDW based on criteria that focuses on the firm's overall bond counsel experience, relevant client base, taxation expertise and staff qualifications. Ms. Mar added that HDW is the second ranked bond counsel firm nationally for long-term bond issues.

HHC Accountable Care Organization (ACO) – November 6, 2013
As reported by Mr. Alan Aviles

The first item on the agenda was to welcome new members to the Board. Mr. Aviles introduced Dr. Luis Marcos, representing the Physician Affiliate Group of New York ("PAGNY"); Dr. Balavenkatesh Kanna, representing the PAGNY Faculty Practice Plans; and Jeromane Berger-Gaskin, a Medicare beneficiary.

The next agenda item was a report from the Chief Executive Officer of the Corporation, Dr. Ross Wilson. Dr. Wilson began with a high-level overview of accountable care, a healthcare payment model that incentivizes the achievement of the Triple Aim. If an Accountable Care Organization ("ACO") is able to demonstrate improved care and reduced costs to Medicare, it can share in the savings up to fifty percent. In a one-sided risk environment, there is no penalty to the ACO if it fails to reach benchmarks.

Research indicates that there is no relationship between the quality and cost of healthcare services. The more money spent does not always equate to better care, and lower spending is not necessarily linked to diminished outcomes. The ACO model challenges groups of healthcare providers to identify and address the factors that are driving spending, other than quality.

ACO arrangements are underway across the country, with a greater concentration on the east coast. A small number of the 32 ACOs that joined the Pioneer program have dropped out because the burden of the startup work was not pre-paid by the incentive available. For some organizations, an ACO may not currently be sustainable. However, it is critical to learn about this model because the healthcare payment system is moving toward shared savings. The HHC ACO is participating in the Medicare Shared Savings Program ("MSSP") to prepare for this future state.

Dr. Wilson then described characteristics of the approximately 13,000 Medicare beneficiaries currently attributed to the HHC ACO. As compared to all beneficiaries attributed to MSSP ACOs nationwide, the HHC ACO population has slightly more end-stage renal disease, and significantly higher rates of disabled and aged dual-eligible beneficiaries. The top diagnoses are diabetes and major psychiatric disorders.

Medicare data showing expenditures for HHC ACO beneficiaries versus the national fee-for-service population indicate that HHC spent more money on inpatient care than the national average, less money on skilled nursing facilities, less on outpatient/Part B care, approximately the average on home health and durable medical goods, and significantly less on hospice. Ms. Zurack inquired whether the Medicare data was adjusted to reflect regional rate differentials. Dr. Wilson indicated that this is preliminary data to be used as a starting point for further conversation rather than drawing conclusions.

Medicare also provided data on the causes of inpatient admissions for HHC ACO beneficiaries. The admission rate for heart failure has been steadily declining in recent years. For uncontrolled diabetes and diabetes short-term complications, the admission rate is high. The HHC ACO is seeking to better understand the difference between the asthma and chronic obstructive pulmonary disease admission rates. The HHC ACO will review data on the number of ambulatory visits by facility as a guide to focus its clinical outreach and education efforts.

Elmhurst Hospital Center ("Elmhurst") patients are not included in this dataset, because until recently the Part B charges for this population were billed through the tax identification number ("TIN") for Icahn School of Medicine at Mount Sinai ("Sinai"). Sinai recently obtained and began billing under a new TIN for the providers delivering services at Elmhurst, which should permit these patients to be attributed to the HHC ACO beginning in 2014.

Mr. Aviles inquired about the total number of Medicare beneficiaries currently attributed to the HHC ACO. Dr. Wilson responded that it is more than 13,000 beneficiaries. The HHC ACO is seeing quarterly churn based on where beneficiaries receive the plurality of their primary care services. Mr. Aviles asked about how many beneficiaries were likely to be attributed in the short term. Dr. Wilson indicated that the HHC ACO might see another 3,000 once the Elmhurst patients are attributed.

Dr. Marcos questioned how many Medicare patients are treated by HHC. Dr. Wilson noted that the HHC ACO serves the Medicare fee-for-service population, which is a small percentage of the overall Medicare population. Ms. Zurack indicated that a new payer-mix report was forthcoming that would provide precise figures.

Dr. Marcos asked how Medicare assigns beneficiaries to an ACO. Dr. Wilson explained that Medicare retrospectively evaluates where primary care services were delivered and attributes patients to the ACO that provided the plurality of such services. In the local environment, Sinai and Montefiore are the two largest ACOs to which patients that also receive care at HHC are being attributed. NYU does not have an ACO at the present time, due to its focus on bundled payment models rather than shared savings. Mr. Russo stated that the threshold for assignment is the "plurality" rather than "majority" of primary care services, because there could be multiple sites where patients receive care.

Dr. Wilson distributed a document outlining the activities undertaken by the HHC ACO in the last twelve months. Medicare is closely monitoring all aspects of MSSP ACO operations. HHC ACO personnel participate on a monthly conference call with a CMS Coordinator. The HHC ACO is satisfying the all MSSP requirements and will report on quality measure performance for 2013 in the first quarter of 2014.

The HHC ACO was required to send all attributed beneficiaries a standard letter to inform them of the ACO and provide opportunity to opt out of having their Medicare claims data shared. A very small number of beneficiaries declined data sharing. The HHC ACO established a hotline

for patients to call with questions. Mr. Russo inquired whether that service was managed in-house or contracted. Dr. Wilson responded that it was managed by HHC ACO personnel out of Central Office. To the extent appropriate and possible, the HHC ACO makes use of HHC resources. Ms. Zurack introduced Jay Weinman, Corporate Comptroller, and noted that the HHC ACO will need to carefully account for all expenses.

The HHC ACO communications strategy is being implemented, beginning with presentations to facility-level leadership and doctors. A physician advisory group will be established to discuss how the ACO can improve patient care. The HHC ACO wants to avoid having two standards of care across HHC, so any innovations developed for this group will be broadly applied. The HHC ACO also has a website.

Sinai recently signed a Participation Agreement to add providers delivering services at Elmhurst to the HHC ACO. As a Participant, Sinai is eligible to have access to the Board and share in the distribution of savings.

Most HHC ACO activity to date relates to working with Bert Robles and the information technology ("IT") department to automate quality reporting on the 33 ACO indicators. Some data will need to be manually abstracted. IT engaged an external vendor that specializes in MSSP ACOs to assist with data collection and reporting. IT is dedicating significant effort to developing an ACO patient registry and integrating data sources, which should be fully functional in 2014.

Medicare will begin providing claims data next month, which will enable the HHC ACO to understand all costs to Medicare associated with the attributed beneficiaries, even for care delivered outside of HHC. Using this claims data, HHC will also have the opportunity to analyze its billing practices. Mr. Aviles questioned how current the claims data will be. Dr. Weisman responded that there would be approximately a three-month lag, to allow Medicare time to adjudicate the claims.

The HHC ACO is yet to build infrastructure to monitor the financial aspects of its operations, particularly the internal costs. However, recordkeeping is in place to enable this to occur. The challenge will be allocating costs incurred by the HHC ACO through existing HHC employees and structures. Most of the costs at the present time are fairly low.

Dr. Wilson expressed confidence that the HHC ACO would be able to successfully report and be evaluated by Medicare this year; however, the HHC ACO does not project savings in the first performance year. In order to share savings, an ACO must both satisfy quality reporting requirements and reduce costs. Ms. Zurack asked whether Medicare provided a benchmark against which savings would be calculated. Dr. Wilson noted that Medicare has modified its formula for calculating savings on several occasions, which is further complicated by HHC's arrangements for Part B billing. The HHC ACO will withhold judgment on the benchmarks or the expected financial outcomes for this year until Medicare provides claims data in December.

Mr. Aviles inquired whether the HHC ACO has independently validated Medicare's attribution of fee-for-service beneficiaries, because the number seems low given the total number of Medicare patients served by HHC. Dr. Wilson responded that HHC's finance department conducted an analysis during the MSSP application phase. This analysis predicted that the HHC ACO would have 12,000 to 25,000 attributed beneficiaries based on a threshold of two primary care visits. Many individuals had emergency department visits without any primary care visits, and it was unknown whether those patients received primary care elsewhere. Mr. Aviles asked if this data included primary care visits with faculty practice plans as well as HHC primary care visits. Ms. Zurack indicated that it did, because faculty practice plan visits mirror technical visits.

The composition of the HHC ACO Board has changed since the last meeting. The leaders of the four PAGNY professional corporations recently convened to nominate a single representative to the HHC ACO Board. Dr. Kanna was selected by his peers for a one-year term. PAGNY also has a dedicated seat on the Board, occupied by its Chief Executive Officer Dr. Marcos. Ms. Berger-Gaskin serves on the Board as a Medicare beneficiary to keep patient care at the forefront of HHC ACO activities.

To date, the HHC ACO has been highly focused on developing its infrastructure. Over the next 12 months, the HHC ACO will have a reasonable understanding of quality and claims performance against Medicare benchmarks. The HHC ACO will need to formalize its mechanical and business structures, and finalize a compliance plan.

The next item of business was the distribution of the *Acknowledgement of Fiduciary Duties and Responsibilities* ("Acknowledgement") identified as item three on the Agenda. Mr. Aviles asked each Board member to review and sign the Acknowledgement, which is required by state law because the HHC ACO is a public authority. The Acknowledgement is a statement by Board members that they understand the mission of the HHC ACO and their fiduciary responsibility to act in the best interests of the HHC ACO.

The next item of business was consideration of a Resolution that relates to officers of the Corporation. A motion was made and duly seconded to adopt the Resolution identified as number four on the Agenda that was previously distributed to the Board:

RESOLUTION authorizing that the following persons are hereby elected to serve in the offices of the Corporation set forth opposite his or her name below, to serve, subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified:

Name	*Office*
Alan D. Aviles	*Chairman*
Ross Wilson, M.D.	*Chief Executive Officer*
Marlene Zurack	*Treasurer*
Salvatore J. Russo	*Secretary*

There was no further discussion of the motion. The motion was unanimously approved.

The next item of business was consideration of a Resolution that relates to the establishment of a Governance Committee of the Corporation. A motion was made and duly seconded to adopt the Resolution identified as number five on the Agenda that was previously distributed to the Board:

RESOLUTION authorizing the establishment of a Governance Committee of the Corporation, pursuant to Article 4, Section 4.11 of the Corporation's by-laws and whose purposes and powers are set forth in its Charter (Exhibit C) annexed to the Resolution, and such Governance Committee shall be comprised of the following three persons, subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified:

Name
Alan D. Aviles
Antonio D. Martin
Ross Wilson, M.D.

Mr. Russo explained that the Governance and Audit Committees were being established to meet the requirements of the Public Authorities Accountability Act.

There was no further discussion of the motion. The motion was unanimously approved.

The next item of business was consideration of a Resolution that relates to the establishment of an Audit Committee of the Corporation. A motion was made and duly seconded to adopt the Resolution identified as number six on the Agenda that was previously distributed to the Board:

RESOLUTION authorizing that Marlene Zurack is relieved of her responsibilities to perform the audit functions of the Corporation, which audit functions are being assumed by an Audit Committee of the Corporation, established pursuant to Article 4, Section 4.11 of the Corporation's by-laws and whose purposes and powers are set forth in its Charter (Exhibit D) annexed to the Resolution, and such Audit Committee shall be comprised of the following three persons, subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified:

Name
Antonio D. Martin
Salvatore J. Russo
Luis R. Marcos, M.D.

Ms. Zurack asked Mr. Russo whether he had spoken with Wayne McNulty, Chief Corporate Compliance Officer, regarding his view of potential conflicts of interest. Mr. Russo confirmed that there are no conflicts of interest because the CEO and Chairman of HHC ACO will not serve on the Audit Committee. The Audit Committee members will operate independently in auditing the Corporation.

There was no further discussion of the motion. The motion was unanimously approved.

The final item of new business was consideration of a Resolution that relates to expanding the number of Directors on the Board. A motion was made and duly seconded to adopt the Resolution identified as number seven on the Agenda that was previously distributed to the Board:

RESOLUTION authorizing that the number of Directors of the Corporation's Board of Directors be fixed at nine, subject to approval by the Centers for Medicare and Medicaid Services ("CMS") of the Participation Agreement executed between the ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI doing business as Mount Sinai Elmhurst Faculty Practice Group ("Elmhurst FPP") and the Corporation; AND

Authorizing, upon such CMS approval, that the person designated below is hereby elected to serve as an additional Director of the Corporation's Board of Directors, subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified, subject to approval and ratification by the Corporation's sole Member, the New York City Health and Hospitals Corporation ("HHC"):

A Director to be named by the Elmhurst FPP, as specified in a writing by the Elmhurst FPP that is delivered to the Chairman of the Corporation; AND

Authorizing, upon such CMS approval, that the existing non-HHC Participants Director shall hereafter be named pursuant to a designation by a majority in number of the Corporation's ACO Participants, as defined in 42 C.F.R. Part 425, other than HHC and the Elmhurst FPP, that have executed Participation Agreements with the Corporation, which Director is specified in a writing signed by such majority that is delivered to the Chairman of the Corporation

Mr. Russo noted two primary aspects of the Resolution. First, the MSSP regulations specify that 75% control of the Board of Directors for an ACO must be held by Participants. Ms. Berger-Gaskin and Dr. Marcos do not meet the technical definition of Participants. Second, the by-laws of the Corporation and the Certificate of Incorporation establish the HHC ACO as a membership corporation with HHC as the sole member. Expansion of the HHC ACO Board must be approved by the full HHC Board of Directors. Mr. Aviles explained that the Elmhurst FPP will designate an individual to fill this new position at a later date.

Ms. Zurack asked for clarification about how the Elmhurst FPP is defined. Dr. Wilson answered that it includes Elmhurst physicians that previously billed under Sinai's TIN, who will now bill under a separate TIN for services rendered to patients at Elmhurst. Ms. Zurack advised that the name used in the Resolution may not be the ultimate name associated with the Elmhurst FPP. Mr. Aviles responded that if the name is subsequently changed, the Resolution will be duly updated.

Dr. Marcos questioned whether the Elmhurst FPP would have a separate incorporation from Sinai, with its own by-laws and governance. Mr. Russo stated that was unknown but that the Elmhurst FPP satisfies the requirements of a Participant. The group has a unique TIN and will conform to all requirements to uphold the TIN. Dr. Wilson explained that Sinai has a different relationship and legal structure with the Elmhurst FPP than PAGNY has with its professional corporations.

There was no further discussion of the motion. The motion was unanimously approved.

Mr. Aviles asked whether there was any additional business. Dr. Wilson reminded the Board that it does not have the power to independently alter its members of by-laws. Certain resolutions approved by the HHC ACO Board are subject to ratification by the full HHC Board of Directors.

Ms. Berger-Gaskin inquired about the strategy for conducting outreach to community members about the HHC ACO. Dr. Wilson explained that the HHC ACO's communications have been limited to assigned beneficiaries and their providers. Because the HHC ACO represents only a small percentage of the overall population served by HHC, it is difficult to reach out to the general community on this topic. Dr. Wilson suggested that Ms. Berger-Gaskin meet with Dr. Weisman so that the HHC ACO might benefit from her recommendations in this regard.

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

ALAN D. AVILES
HHC PRESIDENT AND CHIEF EXECUTIVE
REPORT TO THE BOARD OF DIRECTORS
DECEMBER 19, 2013

HARLEM HOSPITAL CENTER JOINT COMMISSION SURVEY

Last week, The Joint Commission conducted its triennial survey of Harlem Hospital Center, several months earlier than anticipated. The four-day survey was conducted by a team of six surveyors comprised of a physician, two nurses, an administrator, a Life Safety Code surveyor and a Behavioral Health surveyor. Harlem received findings in the environment of care. There were no patient care, quality or safety findings.

The surveyors praised both leadership and staff for "the excellent care provided, with limited resources, to a fairly compromised population with unique issues." They were very impressed with the level of staff and physician engagement, and the team leader commented that "Harlem is a premier HHC facility with clinical and frontline staff who are competent, compassionate, caring, enthusiastic, involved and engaged."

Congratulations to the leadership of Harlem Hospital, led by Denise Soares, RN, Senior Vice President, Maurice Wright, MD, Medical Director, Ebone Carrington, COO, Yanick Joseph, RN, CNE, Consuelo Dungca and James Acero, Quality Management, Jo-Ann N. Liburd, Central Office Accreditation and Regulatory Services, and all of the staff of Harlem Hospital Center for a job well done. Thanks also to our Board Chairman Dr. Stocker and the Harlem CAB Chairperson Bette White, who participated in the survey Leadership Session.

In 2014, The Joint Commission will conduct unannounced surveys at Bellevue, Coler, Henry J. Carter, North Central Bronx, Queens and Woodhull.

KINGS COUNTY HOSPITAL WINS FEDERAL AWARD FOR OPIOID TREATMENT PROGRAM

Kings County Hospital Center announced recently that its substance abuse treatment program for opioid users helped drug addicted individuals remain in treatment longer, increasing their chances of recovery. After adopting a series of interventions, including reducing wait times for admission, assigning patient navigators and offering peer support for opioid users, the hospital achieved a 95 percent retention rate for its 30-day treatment program. This high patient retention rate earned Kings County Hospital this year's Science and Service Award from the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

The federal award for improved retention rates comes when, between 2003 and 2009,

there was an increase of about 40 percent in the number of New York City residents reporting misuse of these drugs. In 2011, opioid analgesics were involved in 220 unintentional deaths in New York City, a 65 percent increase from 2005.

To achieve the higher patient retention rates, the hospital adopted the following operational and clinical strategies:

- Created a same-day admission process that reduced admission wait times by over 50 percent and reduced paperwork and administrative tasks, giving staff more time to focus on patients;
- Established a new welcome committee of staff who explain to every patient the roles of each individual in their care team;
- Assigned each patient a "patient navigator" to identify and resolve barriers to the patient remaining in care, such as housing, transportation, or childcare needs;
- Designated an outreach worker to initiate re-engagement efforts following a single missed program visit by any patient;
- Introduced a peer-led orientation on the day of admission for each patient.

The Kings County Hospital opioid dependency treatment program has capacity to treat up to 750 patients at a time who are addicted to opioids like morphine, heroin, codeine, and oxycodone. In 2012, approximately 240 new patients entered the program.

HHC FACILITIES REAPPLYING FOR RECOGNITION AS PATIENT-CENTERED MEDICAL HOMES

As you know, the HHC adult, pediatric and HIV primary care practices are all currently reapplying for recognition as Patient-Centered Medical Homes (PCMH), and the vast majority have been recognized again. The standards now applied by the National Committee for Quality Assurance (NCQA) are more rigorous than those used when care practices received their first recognitions in 2010, and HHC facilities have all scored very high -- well above the minimum requirement for the top Level III recognition that assures the maximum level of enhanced revenue for Medicaid patients -- about $18-20 million annually in recent years. There are now 13 facilities that have achieved recognition. Two additional applications will be submitted this month and the final two will be submitted at the beginning of 2014.

METROPLUS HEALTH EXCHANGE ENROLLMENTS CONTINUE TO RISE

MetroPlus enrollments from the New York State Health Exchange continue to increase by about 1,000 applicants each week. As of yesterday, 9,748 applicants have enrolled in our Metroplus Qualified Health Plans on the new health insurance exchange, with coverage scheduled to begin January 1. The MetroPlus plans, which offer some of the lowest costs available on the New York State exchange, continue to attract younger and

relatively healthy participants. Of the applicants that have chosen MetroPlus, 72 percent are under the age of 50. More than 700 additional applicants have also signed up for MetroPlus through Medicaid, Child Health Plus and the SHOP plans for employer groups.

BOARD CERTIFICATION IN CLINICAL INFORMATICS

HHC's Chief Medical Informatics Officer, Dr. Louis Capponi, has received Board Certification from the American Board of Preventive Medicine, as part of the first class ever certified in the field of clinical informatics.

Clinical informatics is a relatively new specialty area in medicine and is principally aimed towards healthcare transformation. Specialists in informatics analyze, design, implement, and evaluate information and communication systems. These activities occur at both the individual patient level and at the population level. Clinical informatics combines knowledge from the domains of health systems operations, clinical care, and information and communications technology.

Physicians who are board-certified in clinical informatics collaborate with other healthcare and information technology professionals to promote patient care that is safe, efficient, and effective. Their knowledge of patient care, combined with the understanding of informatics methods and tools, enable them to focus on a variety of changes in healthcare, including the strengthening of the clinician-patient relationship and the improvement of patient outcomes.

Congratulations to Dr. Capponi for demonstrating so ably the leadership that HHC continues to provide in information technology and healthcare reform.

PATIENT SAFETY FORUM ON THE FUTURE OF HEALTHCARE

On December 11, the Division of Safety and Human Development, Office of Patient Safety and Employee Safety convened a patient safety forum for network, facility and Central Office leaders on The Future of Healthcare featuring a keynote address by Martin A. Makary, MD, MPH, Chief of the Johns Hopkins Pancreas Islet Transplantation Center and Director of Surgical Quality and Safety. Dr. Makary is the nationally renowned author of the book Unaccountable. In his compelling presentation, Dr. Makary focused on the critical role of both accountability and data transparency in improving quality and safety performance in medical care and healthcare. It is his premise that these two ingredients are essential to reducing performance variability among clinicians and hospitals and in driving improved outcomes.

Following the keynote, Dr. Makary led a workshop for participants where they were asked to work together in teams to identify variability in their current processes that may lead to patient harm and develop "pledges" or specific actions they can take to

increase transparency and trust and engage patients.

I highly recommend and am happy to provide interested members of the Board a copy of Dr. Makary's book ***Unaccountable***.

THE THIRD ANNUAL PATIENT ADVOCATE CONFERENCE AND WORKSHOP

On December 6, Abdul Mondul, MD, Associate Medical Director, Chief Palliative Care Services and Patient Safety Officer at Lincoln Medical Center; Mei Kong, RN, Assistant Vice President, Patient Safety and Employee Safety; and Harold Hellman, Patient Safety Officer at Dr. Susan Smith McKinney gave a presentation entitled "No Decisions About Me Without Me: Partnering for Safe Care" at the Third Annual Patient Advocate Conference and Workshop in Orlando, Florida. This event was sponsored by The Professional Patient Advocate Institute. The objectives of the session were to: incorporate TeamSTEPPS® into patient and family interactions; provide information that will challenge providers to change their patient/family interactions to a more patient-centered, fully informed partnership model; teach tactics for educating patients and their families about the available treatments, alternatives, and the option to do nothing at all; and provide strategies for presenting information in ways that consumers can relate to and better understand.

FEDERAL UPDATE

Last week, Congressional leaders agreed to a two-year budget agreement. The highlights of the agreement include $85 billion in spending cuts and the replacement of most of the sequester cuts with revenue derived from the imposition of various fees. The bill was passed in both the House and the Senate.

Unfortunately, the sequester-mandated 2 percent reduction in payments made to Medicare providers remains and is extended to 2023. These Medicare 2 percent reductions will cost HHC roughly $18 million a year.

Attached to the Bipartisan Budget Act of 2013 are provisions that would provide three months of relief for doctors who participate in the Medicare program. This temporary three month patch, costing $7 billion, should give Congress enough time to finalize the provisions of a permanent "fix" to the Medicare physician payment during the early part of the next calendar year. Without Congressional intervention, physician's Medicare payments are slated to be reduced by 20.1 percent on January 1.

As part of the offset for this patch, a number of provisions impacting HHC were included. One provision extended the Medicaid Disproportionate Share Hospital (DSH) reductions by one more year to 2023. This could cost HHC a total of $421.8 million that year (assuming the local match is also lost). On the positive side, the national 5 percent

mandated Medicaid DSH cuts were delayed for 2014 and 2015; these cuts could have reduced HHC's funding by about $56.5 million in each of those years. The Medicaid DSH cut slated for 2016, originally 5 percent, now has been doubled to 10 percent, increasing HHC's proportional estimated cut in 2016 to $113 million.

The hospital industry is pleased over the delay of these initial Medicaid DSH cuts but the long-term dire threat to Medicaid DSH remains.

Another significant offset in the legislation is a change in the criteria defining what constitutes a long-term Care Hospital (LTCHs). The changes mandate that 50 percent of total discharges be patients who were either originally in an Intensive Care Unit for three days before coming to the LTCH or were patients on ventilators. The new criteria could create major problems for HHC's new Henry J. Carter LTCH in that it is unclear whether or when Carter could comply given the safety net role that Carter plays, with its mostly Medicaid patient base. The new requirement would need to be met by October 1, 2015. We are working with our Congressional delegation to address these issues and will keep you up to date on developments.

HHC LAUNCHES NEW CORPORATE WEBSITE

This week HHC did a "soft launch" of a new corporate website, designed to be more patient-centered and accessible to all of our audiences. Its features include:

- A more pleasing visual style with larger photos and graphics;
- Reorganized content that is more consumer-friendly;
- A new, more comprehensive map of our facilities that includes our many community-based health centers;
- A feature that allows patients to search by healthcare service;
- New, updated content to emphasize the high quality of our healthcare, the innovation we demonstrate and the leadership we've shown in healthcare reform;
- Clear messaging about preventive healthcare and Patient-Centered Medical Homes;
- Clearer descriptions of the many healthcare services we provide; and
- Messaging that we strive to provide one integrated healthcare system.

The new website still has many of the features that are helpful to our patients and stakeholders: it can be translated into many different languages and the text can be enlarged to help those with vision challenges. We will formally announce the new site next month and begin to promote it. You will see a full demo of the new site in a special presentation at our next Board meeting. In the meantime, please visit our new website at nyc.gov/hhc and give us your feedback.

INTRODUCING HHC'S GUIDING PRINCIPLES

Throughout most of 2013, I asked HHC leadership and others to participate in a dialogue about building a set of Guiding Principles that will help every HHC employee to align their work -- wherever they are in the organization -- with our mission and our strategic direction. Included in your packet today is a graphic depiction of these guiding principles and a printout briefly describing each of them.

The Guiding Principles, in a sense, attempt to anchor our work going forward around organizational values that are critical to our future success, and to do so in the simplest, most straightforward way. In another sense, the Guiding Principles are aspirational. They reinforce six essential features that should characterize our daily work individually and collectively: a patient-centered approach, a relentless focus on safety, a commitment to excellence, a steady eye on cost savings and resource management, a proficiency with effective teamwork, and a devotion to, and support for, continuous learning for everyone in the organization.

The Guiding Principles graphic is designed to evoke these core principles and to connect them to the goals of the Triple Aim of better health, better care, and better value. Although safety is at the top of the graphic and patients are at the center, a circular shape reinforces the idea that all of the principles are equally important. And as you will see, supporting, defining language – which is still a work in progress -- provides additional guidance in a clear and straightforward way.

I will end today's report by showing a brief video where I introduce the Guiding Principles and begin to relate them to our strategic initiatives and every day work.

Going forward, we will introduce them again and again to reinforce the important role that each of them plays in guiding us toward providing the best care possible to our patients and communities.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

Program Integrates Mental Health Care With Medical Care, Dr. Leonel Urcuyo, Chief of Psychiatry, Dr. Michelle Soto, Director, Center for Integrated Health, Woodhull, NY1 News, 12/04/13

Lincoln Hospital Integrated Wellness Center, Dr. Marieliz Alonso, Lincoln Hospital, News 12 Bronx, 12/16/13

Coordinated Procedure Allowed Large Numbers To Be Treated At Once Following

Derailment, Dr. George Agriantonis, Elmhurst Hospital, NY1 News, 12/02/13

Children's Health and Safety During the Holidays, Dr. Randy Nunez, Lincoln Hospital, Bronxnet-TV, 12/11/13

Print

How Long Can City Hospitals Stay a 'Going' Concern?, Alan D. Aviles, President, LaRay Brown, Senior Vice President, Marlene Zurack, Chief Financial Officer, HHC, Capital New York, 12/03/13

Harlem Specialty Hospital and Nursing Facility Opens, Harlem World, 11/30/13

Former Goldwater Hospital Patients Arrive at $285M East Harlem Facility, Henry J. Carter Specialty Hospital and Nursing Facility, Coler-Goldwater, Margaret Rivers, Associate Executive Director, DNAinfo.com, 12/17/13

New York Yankee Great CC Sabathia Visits Henry J. Carter Specialty Hospital and Nursing Facility, The New York Amsterdam News, November 28-December 4, 2013

As a Specialty Care Hospital Prepares to Close, Patients Wonder What's Next, Executive Director Robert K. Hughes, Coler-Goldwater Hospital, Henry J. Carter Hospital, The New York Times, 11/21/13 (Also covered in the Cornell Daily Sun)

Hospitals Push Coverage - Insured Patients Are Gold for Centers Hit by Federal Cuts in Charity-Care Funds, Alan D. Aviles, HHC, The Wall Street Journal, 11/20/13

Lincoln Opens Integrated Wellness Center The Bronx Free Press, November 29-December 5, 2013 (Also covered in MD News)

Hospital Achieves 95 Percent 30-Day Retention Rates in Outpatient Opioid Program, Dr. Susan Whitley, Kings County Hospital, Alcoholism and Drug Abuse Weekly, 11/25/13

Sharing & Caring Honors Those Who Help Heal, Dr. Marlon Brewer, Elmhurst Hospital Julius Wool, Executive Director, Queens Hospital, Queens Gazette, 11/20/13

Coney Island Hospital Doles Out 102 Thanksgiving Turkeys To Pediatric Patients In Need, Sheepsheadbites.com, 12/02/13

Elmhurst Hospital Center Provides Thanksgiving Dinners, Queens Gazette, 12/18/13

How Your Doctor Feels About You Could Affect Your Care, Dr. Danielle Ofri, Bellevue,

WUWM Milwaukee Public Radio, 12/03/13

Muscle Aches From Statins? Drug Interactions May Play a Role, Dr. James A. Underberg, Director, Lipid Clinic, Bellevue Hospital, The New York Times, 12/04/13

Don't Let the Winter Blues Get You, Dr. Miklos Losonczy, Lincoln, The Bronx Free Press, November 27-December 3, 2013

VAP Round II, Kings County, Crain's Health Pulse, 12/04/13

Top Hospitals Named for Transparency, Harlem Hospital, Healthcare IT News, 12/05/13

Famous Famiglia Opens at Roosevelt Ave. Transit Hub After Long Delay, Elmhurst Hospital, DNAinfo.com, 12/09/13

Quality Improvement Fellowships Spread Innovation, Spur Careers , Dr. Amanda Asher, Segundo Ruiz Belvis Diagnostic and Treatment Center , North Central Bronx, HHC, United Hospital Fund Blueprint, Fall/Winter 2013

Cuomo Spars with Obama Administration Over Medicaid Exemption, HHC,The Washington Post, 12/12/13

House Budget Tweak Costs N.Y. Hospitals Millions, HHC, Capital New York, 12/12/13

Safety in Toyland: Choose toys that promote health, education and safety, Milton Nunez, Executive Director, Lincoln, Bronx Free Press, December 11, 2013

Elmhurst Hospital Doctors Say Pedestrian Injuries are Continuing to Rise in Queens, Dr. Jaime Ullman, Elmhurst Hospital, New York Daily News, 12/16/13 (Also covered in AmNY, Newsday, Streetsblog.com)

New York State Hospital Cost Data Expose Big Markups, and Odd Bargains, Kings County Hospital , The New York Times, 12/09/13 (Also covered by Washington Post and WNYC Radio)

APPROVED: December 19, 2013

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Hawkins Delafield & Wood LLP ("Hawkins") to provide bond counsel services related to the structuring and continuing implementation of the Corporation's financing program for the period beginning December 1, 2013 through November 30, 2016, plus two one-year renewal options solely exercisable by the Corporation. The hourly rates are: $420 for Partners, $360 for Senior Associates, $280 for Associates, $210 for Junior Associates, and $150 for paraprofessionals.

WHEREAS, the Corporation currently finances major capital projects, ongoing capital improvements and major movable equipment through funds received from the proceeds of tax-exempt bonds and/or leases issued by the Corporation or by other issuers on behalf of the Corporation; and

WHEREAS, the specialized services of experienced bond counsel are needed to prepare and review documents, to issue formal independent legal opinions relating to security and tax law, and other areas, and to provide related legal advice; and

WHEREAS, Hawkins has served as bond counsel to the Corporation since 1995; and

WHEREAS, Hawkins' extensive health care experience and outstanding reputation among the credit rating agencies and the investment banking community has served the Corporation very well in the past; and

WHEREAS, through a Request for Proposals ("RFP") process for bond counsel services, a selection committee determined that Hawkins Delafield & Wood LLP is best qualified to provide the bond counsel services required; and

WHEREAS, the overall management of this contract will be under the direction of the Senior Vice President, Finance/Chief Financial Officer and Assistant Vice President, Debt Finance/Corporate Reimbursement Services.

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 Hawkins Delafield & Wood LLP to provide bond counsel services related to the structuring and continuing implementation of the Corporation's financing program for the period beginning December 1, 2013 through November 30, 2016, plus two one-year renewal options solely exercisable by the Corporation. The hourly rates are: $420 for Partners, $360 for Senior Associates, $280 for Associates, $210 for Junior Associates and $150 for paraprofessionals.

APPROVED: December 19, 2013

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to enter into a contract to purchase software, hardware, services and corresponding maintenance for a biomedical middleware software solution with iSirona, LLC (the "Contractor"). through a Federal General Services Administration ("GSA") contract in an amount not to exceed $6,454,161, which includes a 10% contingency of $586,742 for a one year term with four one-year options to renew at the Corporation's exclusive option.

WHEREAS, the Corporation has over 45,000 biomedical devices in place today that are being monitored manually by clinical staff; and

WHEREAS, the data from these devices is being entered manually into the Electronic Medical Record ("EMR") allowing for the possibility of transcription errors, patient ID errors, delayed documentation and data omission; and

WHEREAS, the proposed contract will allow the Corporation to implement a solution that will automatically take the critical patient data from these devices and send the results to the EMR; and

WHEREAS, this solution will greatly improve the efficiency of the Corporation's clinicians and improve patient safety by enabling automatic updates rather than manual updates to a patient's EMR; and

WHEREAS, the Corporation issued a biomedical middleware software and services RFP to which the Contractor responded; and

WHEREAS, the Contractor is able to provide middleware software and hardware, which will be used to integrate the Corporation's biomedical devices with the EMR system utilizing the InterSystems Ensemble integration engine; and

WHEREAS, the overall responsibility for managing and monitoring the agreement shall be under the Senior Vice President/Corporation Chief Information Officer.

NOW, THEREFORE, be it:

RESOLVED THAT the President of the New York City Health and Hospitals Corporation ("the Corporation") be and hereby is authorized to enter into a contract to purchase software, hardware, services and corresponding maintenance for a biomedical middleware software solution with iSirona, LLC. through a Federal General Services Administration contract in an amount not to exceed $6,454,161, which includes a 10% contingency of $586,742 for a one year term with four one-year options to renew at the Corporation's exclusive option.

APPROVED: December 19, 2013

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute contracts with various authorized resellers on an on-going basis over a one year period for the purchase of Cisco networking equipment and software through NYS Office of General Services ("OGS") contracts in an amount not to exceed $4,188,853, which includes a 20% contingency.

WHEREAS, the Corporation has several hundred servers to support the Corporation's new electronic medical record ("EMR") system, which are utilized to manage clinical, financial and administrative data throughout the Corporation to support business and clinical applications pertaining to patient care; and

WHEREAS, the Cisco networking equipment and software are required to connect the various servers holding EMR data into the Corporation's network; and

WHEREAS, failure to obtain this equipment and software for the Corporation's network will result in the inability to deploy the EMR system with adverse impacts on patient care; and

WHEREAS, the Corporation will solicit proposals from Cisco Inc.'s authorized resellers who offer Cisco equipment and software for sale through OGS contracts; and

WHEREAS, OGS contract prices for such equipment and software are discounted from market price; and

WHEREAS, contracts will be issued to the OGS vendors offering the lowest price for the requested equipment and software; and

WHEREAS, the overall responsibility for managing and monitoring these contracts shall be under the Senior Vice President/Corporate Chief Information 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 contracts with various authorized resellers on an on-going basis over a one year period for the purchase of Cisco networking equipment and software through NYS Office of General Services ("OGS") contracts in an amount not to exceed $4,188,853, which includes a 20% contingency.

APPROVED: December 19, 2013

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to purchase from Dyntek Services, Inc. (the "Vendor") through a NYS Office of General Services ("OGS") contract F5 Load Balancers hardware, software and services in an amount not to exceed $4,448,182, which includes a 15% contingency of $580,198.

WHEREAS, the Corporation has an immense inventory of routers, switches, firewalls, servers and wireless controllers, which are utilized to link various computers and data systems throughout the Corporation together to share business and clinical applications used for patient care; and

WHEREAS, the F5 Load Balancers are required to avoid outages associated with traffic congestion over the network; and

WHEREAS, failure to obtain such hardware, software and services for the Corporation's network infrastructure may result in system unavailability with an adverse impact on patient care; and

WHEREAS, the subject acquisition is needed for the network infrastructure to support the Electronic Medical Record program; and

WHEREAS, the Corporation solicited proposals from vendors who offer their equipment, software and services via the OGS and Federal General Services Administration contracts; and

WHEREAS, the Vendor, Dyntek Services, Inc. offered the lowest price for the requested equipment, software and services; and

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

NOW THEREFORE, be it:

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and he hereby is authorized to purchase from Dyntek Services, Inc. through a NYS Office of General Services contract F5 Load Balancers hardware, software and services in an amount not to exceed $4,448,182, which includes a 15% contingency of $580,198.

APPROVED: December 19, 2013

RESOLUTION

Authorizing the President to negotiate and execute a contract between the New York City Health and Hospitals Corporation (HHC or Corporation) and CareFusion Solutions, LLC ("CareFusion"), to provide automated medication dispensing systems used in the administration of medication and supplies. The proposed contract is an enhanced Premier contract PPPH14CFS that would standardize the cost, support, services and at the same time set an end date for all current active contracts. Currently we spend $23,921,500 on automated medication dispensing systems and we need $4,848,048 in upgrades and additional fees. By doing a single overall contract rather than multiple smaller contracts the corporation would save $5,458,240 over the term of the contract, or $1,091,648 annually. The five (5) year contract cost is $24,447,347 for existing equipment and 73 new rental units. A Contingency of 20% ($4,889,470) has been included to provide expansion opportunities for a total not to exceed amount of $29,336,817.

WHEREAS, on January 9, 2013 the Supply Chain Council approved CareFusion Pyxis as the Corporate standard for automated dispensing system; and

WHEREAS, In December 2012, the Directors of Pharmacy approved the Pyxis MedStation as the standard: and

WHEREAS, HHC is renting CareFusion Pyxis equipment, products and services via various HHC contracts. The cost of the equipment, type of support and services varies across the facilities; and

WHEREAS, a new five year contract would standardize the cost, support, services and conterminously set an end date for all the incorporated contracts with a discount of 57% for all units with a total savings under the contract term of $5,458,240 or $1,091,648 annually; and

WHEREAS, an assessment shall be conducted to determine present and future needs during the term of the agreement by the Pyxis Advisory team comprised of Director of Pharmacy, Office of the Chief Medical Officer, Office of Procurement and EITS representatives; and

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

NOW, THEREFORE be it **RESOLVED**, that the President be and hereby is authorized to negotiate and execute a contract between the New York Health and Hospitals Corporation (HHC or Corporation) and CareFusion Solutions, LLC ("CareFusion"), to provide automated medication dispensing systems used in the administration of medication and supplies. The proposed contract is an enhanced Premier contract PPPH14CFS that would standardize the cost, support, services and at the same time set an end date for all current active contracts. Currently we spend $23,921,500 on automated medication dispensing systems and we need $4,848,048 in upgrades and additional fees. By doing a single overall contract rather than multiple smaller contracts the corporation would save $5,458,240 over the term of the contract, or $1,091,648 annually. The five (5) year contract cost is $24,447,347 for existing equipment and 73 new rental units. A Contingency of 20% ($4,889,470) has been included to provide expansion opportunities for a total not to exceed amount of $29,336,817.

APPROVED: December 19, 2013

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a three year revocable license agreement with Simon and Company (the "Licensor") for its continued use and occupancy of approximately 144 square feet of space including use of the reception area, conference room, library, storage area, kitchen, high-speed internet service and digital cable television at an occupancy fee rate of $1,494 per month or approximately $17,926 per year at 1660 L Street, N.W., Washington, D.C., for use by the Corporation's federal lobbyist

WHEREAS, the Corporation employs a lobbyist who focuses on federal legislative and regulatory affairs and who works full-time in Washington, D.C.; and

WHEREAS, the Licensor holds a lease for a suite of offices at 1660 L Street, N.W., Washington D.C., and rents office space to state and municipal governments for use by their lobbyists; and

WHEREAS, in February 2011 the Board of Directors authorized the President to enter into a three year license agreement with the Licensor for the use of an office in its suite; and

WHEREAS, the Corporation now desires to extend the license agreement for an additional three year period.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and he hereby is authorized to execute a three year revocable license agreement with Simon and Company for its continued use and occupancy of approximately 144 square feet of space including use of the reception area, conference room, library, storage area, kitchen, high speed internet service and digital cable television at an occupancy fee rate of $1,494 per month or approximately $17,926 per year at 1660 L Street, N.W., Washington, D.C. for use by the Corporation's federal lobbyist.

APPROVED: December 19, 2013

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year lease extension agreement with Franciosa Owners, LLC (the "Landlord") for 5,300 square feet of space at 1012 East Gun Hill Road, Borough of the Bronx, to house the Gun Hill Health Center, operated by Jacobi Medical Center (the "Facility") at an initial rent of $29.78 per square foot to increase at 2.5% per year with the Corporation responsible for the payment of real estate taxes, water and sewer rents, and separately metered electricity provided that the Landlord shall perform renovation work which includes exterior storefront replacement, painting, and the installation of two new rooftop HVAC units and installation of a new water heater.

WHEREAS, the Gun Hill Health Center is a community-based health care center that has been providing primary care services to residents of the Woodlawn, Soundview, Tremont-Crotona, Parkchester and Fordham sections of the Bronx since 1998; and

WHEREAS, the Gun Hill Health Center serves a patient population with high rates of low birth weight babies, infant mortality, and neonatal mortality and offers primary care services which include General Medicine, Pediatric and Women's Health Services; and

WHEREAS, there remains a need for primary care services in this section of the Bronx and extending the lease for this site will allow the Gun Hill Health Center to continue to serve the community; and

WHEREAS, the Landlord has offered to upgrade the premises with a complete paint job, new storefront, hot water heater, HVAC units.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be, and hereby is, authorized to execute a five year lease extension agreement with Franciosa Owners, LLC (the "Landlord") for 5,300 square feet of space at 1012 East Gun Hill Road, Borough of the Bronx, to house the Gun Hill Health Center, operated by Jacobi Medical Center at an initial rent of $29.78 per square foot to increase at 2.5% per year with the Corporation responsible for the payment of real estate taxes, water and sewer rents, and separately metered electricity provided that the Landlord shall perform renovation work which includes exterior storefront replacement, painting, and the installation of two new rooftop HVAC units and installation of a new water heater.

APPROVED: December 19, 2013

RESOLUTION

Reappointing Tamira Boynes as a member of the Board of Directors of MetroPlus Health Plan, Inc., a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York ("MetroPlus"), to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

WHEREAS, a resolution approved by the Board of Directors of the New York City Health and Hospitals Corporation ("HHC") on October 29, 1998, authorized the conversion of MetroPlus from an operating division to a wholly owned subsidiary of HHC; and

WHEREAS, the Certificate of Incorporation of MetroPlus reserves to HHC the sole power with respect to appointing members of the Board of Directors of MetroPlus; and

WHEREAS, the Bylaws of MetroPlus authorize the Executive Director of MetroPlus to nominate a Director who is a member of the MetroPlus Health Plan, subject to approval by the Board of Directors of HHC; and

WHEREAS, Tamira Boynes is a member of MetroPlus and has been a member of the Board of Directors of MetroPlus since February 2004; and

WHEREAS, the Executive Director of MetroPlus has selected Ms. Boynes to serve an additional term of five years as a member of the Board of Directors of MetroPlus;

WHEREAS, the Board of Directors of MetroPlus has approved said nomination;

NOW, THEREFORE, be it

RESOLVED, that the HHC Board of Directors hereby reappoints Tamira Boynes to the Board of Directors of the MetroPlus Health Plan, Inc. to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws of MetroPlus.

APPROVED: December 19, 2013

RESOLUTION

Reappointing Meryl Weinberg as a member of the Board of Directors of MetroPlus Health Plan, Inc., a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York ("MetroPlus"), to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

WHEREAS, a resolution approved by the Board of Directors of the New York City Health and Hospitals Corporation ("HHC") on October 29, 1998, authorized the conversion of MetroPlus from an operating division to a wholly owned subsidiary of HHC; and

WHEREAS, the Certificate of Incorporation of MetroPlus designates HHC as the sole member of MetroPlus and has reserved to HHC the sole power with respect to electing members of the Board of Directors of MetroPlus; and

WHEREAS, the Bylaws of MetroPlus authorize the President of HHC to select two directors of MetroPlus' Board subject to election by the Board of Directors of HHC; and

WHEREAS, Meryl Weinberg has been a member of the Board of Directors of MetroPlus since January 2009; and

WHEREAS, the President of HHC has selected Meryl Weinberg to serve an additional 5 year term as a member of the Board of Directors of MetroPlus;

WHEREAS, the Board of Directors of MetroPlus has approved said nomination;

NOW, THEREFORE, be it

RESOLVED, that the HHC Board of Directors hereby reappoint Meryl Weinberg to the Board of Directors of the MetroPlus Health Plan, Inc. to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws of MetroPlus.

APPROVED:December 19, 2013

RESOLUTION

Approving and ratifying the actions of the HHC ACO Inc. Board of Directors to fix the number of Directors of the HHC ACO Inc. Board of Directors at nine, subject to approval by the Centers for Medicare and Medicaid Services ("CMS") of the Participation Agreement executed between the ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI doing business as Mount Sinai Elmhurst Faculty Practice Group ("Elmhurst FPP") and HHC ACO Inc., which CMS approval has since been granted;

AND

Approving and ratifying the actions of the HHC ACO Inc. Board of Directors to elect the person designated below to serve as an additional Director of the HHC ACO Inc. Board of Directors, subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified:

A Director to be named by the Elmhurst FPP, as specified in a writing by the Elmhurst FPP that is delivered to the Chairman of HHC ACO Inc.;

AND

Approving and ratifying the actions of the HHC ACO Inc. Board of Directors that the existing non-HHC Participants Director of the HHC ACO Inc. Board of Directors shall hereafter be named pursuant to a designation by a majority in number of HHC ACO Inc.'s ACO Participants, as defined in 42 C.F.R. Part 425, other than the Corporation and the Elmhurst FPP, that have executed Participation Agreements with HHC ACO Inc., which Director is specified in a writing signed by such majority that is delivered to the Chairman of HHC ACO Inc.

WHEREAS, the Corporation previously appointed certain individuals to serve as the Board of Directors of HHC ACO Inc., as specified in the Certificate of Incorporation of HHC ACO Inc. and a subsequent Resolution of the Corporation's Board of Directors, and now wishes to approve and ratify the actions of the HHC ACO Inc. Board of Directors to (i) fix the number of Directors of the Board of Directors of HHC ACO Inc. at nine and (ii) add a Director to be named by the Elmhurst FPP, subject to approval by CMS of the Participation Agreement executed between the Elmhurst FPP and HHC ACO Inc., which CMS approval has since been granted, and approval by the Corporation;

WHEREAS, the Corporation wishes to approve and ratify actions of the HHC ACO Inc. Board of Directors, which authorized, subject to such CMS approval which has since been granted, and subject to approval by the Corporation, that the existing non-HHC Participants Director of HHC

ACO Inc. shall hereafter be named by a majority in number of HHC ACO Inc.'s ACO Participants other than the Corporation and the Elmhurst FPP.

NOW, THEREFORE, BE IT

RESOLVED, that the Corporation hereby approves and ratifies the actions of the HHC ACO Inc. Board of Directors to fix the number of Directors of the HHC ACO Inc. Board of Directors at nine; and

BE IT FURTHER RESOLVED, that the Corporation hereby approves and ratifies the actions of the HHC ACO Inc. Board of Directors to elect the person designated below to serve as an additional Director of the HHC ACO Inc. Board of Directors, subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified:

A Director to be named by the Elmhurst FPP, as specified in a writing by the Elmhurst FPP that is delivered to the Chairman of HHC ACO Inc.; and

BE IT FURTHER RESOLVED, that the Corporation hereby approves and ratifies the actions of the HHC ACO Inc. Board of Directors that the existing non-HHC Participants Director of HHC ACO Inc. shall hereafter be named pursuant to a designation by a majority in number of the HHC ACO Inc.'s ACO Participants, as defined in 42 C.F.R. Part 425, other than the Corporation and the Elmhurst FPP, that have executed Participation Agreements with HHC ACO Inc., which Director is specified in a writing signed by such majority that is delivered to the Chairman of HHC ACO Inc.

RESOLUTION APPROVED: December 19, 2013

Authorizing that each of the following persons be elected to serve as a Director of the HHC ACO Inc. Board of Directors, subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified:

Alan D. Aviles

Antonio D. Martin

Salvatore J. Russo

Ross M. Wilson, M.D.

Marlene Zurack

Jeroman Berger-Gaskin, a Medicare beneficiary Director

A Director who shall be the Chief Executive Officer of Physician Affiliate Group of New York, P.C. ("PAGNY")

A Director to be named by the ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI doing business as Mount Sinai Elmhurst Faculty Practice Group ("Elmhurst FPP"), as specified in a writing by the Elmhurst FPP that is delivered to the Chairman of HHC ACO Inc.

A Director to be named pursuant to a designation by a majority in number of HHC ACO Inc.'s ACO Participants, as defined in 42 C.F.R. Part 425, other than the Corporation and the Elmhurst FPP, that have executed Participation Agreements with HHC ACO Inc., which Director is specified in a writing signed by such majority that is delivered to the Chairman of HHC ACO Inc.

WHEREAS, the Corporation previously appointed certain individuals to serve as the initial Board of Directors of HHC ACO Inc., as specified in the Certificate of Incorporation of HHC ACO Inc. and subsequent Resolutions of the Corporation and now wishes to authorize a new slate of Directors of HHC ACO Inc.

NOW, THEREFORE, BE IT

RESOLVED, that the Corporation hereby authorizes that each of the following persons be elected to serve as a Director of the HHC ACO Inc. Board of Directors, subject to such person's earlier death, resignation or removal, in accordance with the laws of the State of New York until such person's successor is duly elected and qualified:

Alan D. Aviles

Antonio D. Martin

Salvatore J. Russo

Ross M. Wilson, M.D.

Marlene Zurack

Jeroman Berger-Gaskin, a Medicare beneficiary Director

A Director who shall be the Chief Executive Officer of PAGNY

A Director to be named by the Elmhurst FPP, as specified in a writing by the Elmhurst FPP that is delivered to the Chairman of HHC ACO Inc.

A Director to be named pursuant to a designation by a majority in number of HHC ACO Inc.'s ACO Participants, as defined in 42 C.F.R. Part 425, other than the Corporation and the Elmhurst FPP, that have executed Participation Agreements with HHC ACO Inc., which Director is specified in a writing signed by such majority that is delivered to the Chairman of HHC ACO Inc.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to enter into a contract with EMC Corporation(the "Contractor") for VMWare virtualization software through a NYS Office of General Services ("OGS") contract in an amount not to exceed $4,178,395, which includes a 15% contingency of $545,007 over a three year term.

WHEREAS, the Corporation is undertaking an initiative to upgrade our existing infrastructure by virtualizing our critical infrastructure assets; and

WHEREAS, Enterprise IT Services has recommended that the Corporation use virtualization software to support the new EMR as well as standardizing on virtual desktops throughout the facilities; and

WHEREAS, software server virtualization also reduces costs as there is less hardware required; and

WHEREAS, the Corporation solicited proposals from virtualization resellers who offer their services via New York State OGS contracts and Federal General Services Administration ("GSA") contracts; and

WHEREAS, the Contractor is an authorized reseller of VMWare virtualization software and maintenance; and

WHEREAS, the Contractor offered the lowest price for the requested services and the OGS contract prices for such services and maintenance are discounted from market price; and

WHEREAS, under the proposed agreement with the Contractor, the Corporation will be given an enterprise license agreement with VMWARE to sign that will secure the Corporation's right to use the software and will obligate the Corporation to respect the intellectual property rights of VMWARE but will not involve any financial commitment by the Corporation to VMWARE; and

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

NOW THEREFORE, be it:

RESOLVED, THAT THE the President of the New York City Health and Hospitals Corporation be and hereby is authorized to enter into a contract with EMC Corporation for VMWare virtualization software and maintenance, through a NYS Office of General Services contract in an amount not to exceed $4,178,395, which includes a 15% contingency of $545,007 over a three year term.

EXECUTIVE SUMMARY

The accompanying resolution requests approval to enter into a contract with EMC Corporation (the "Contractor") for VMWare virtualization software through a NYS Office of General Services ("OGS") contract in an amount not to exceed $4,178,395, which includes a 15% contingency of $545,007 over a three year term. A portion of the funding for this purchase will be provided from the EMR budget previously presented to the Board of Directors.

Under the proposed agreement with the Contractor, the Corporation will be given an enterprise license agreement with VMWARE to sign that will secure the Corporation's right to use the software and will obligate the Corporation to respect the intellectual property rights of VMWARE but will not involve any financial commitment by the Corporation to VMWARE.

Through this Enterprise License Agreement ("ELA"), HHC is undertaking an important initiative to upgrade our existing infrastructure by virtualizing our critical infrastructure assets. The software provided in the Enterprise Licensing Agreement will enable HHC to effectively service the EPIC implementation, enhance HHC disaster recover capability, enable a private cloud computing environment and securely deploy "Bring Your Own Device (BYOD)."

EITS has recommended the use of virtualized software to support the new EMR/EPIC application as a technical requirement to service the user community's desktops. Virtual desktop infrastructure (VDI) is the practice of hosting a desktop operating system within a virtual machine (VM) running on a centralized server. VDI is a variation on the client/server computing model, sometimes referred to as server-based computing. This configuration builds efficiencies within the infrastructure environment to allow EITS to redirect these support resources to other high level activities.

Server virtualization has many benefits. Server virtualization reduces costs as there is less hardware is required. Server virtualization conserves space through consolidation as several machines can be combined into one server running multiple virtual environments. It also utilizes resources to their maximum capacity allowing savings on operational costs (e.g. using a lower number of physical servers reduces hardware maintenance).

Similar to the EPIC deployment, "Bring Your Own Device" (BYOD) must be deployed in a secure, HIPAA compliant environment. By utilizing desktop virtualization, all devices will use a virtual server to access critical applications and files using smartphones, iPad and Android-based tablets and desktops. No files will be stored on these devices, only on the virtualized servers.

The new ELA has the potential to avoid costs by standardizing virtual desktops and minimizing the resources necessary to support this environment. The non-bundled renewal cost of the requested desktop and service virtualization would total over $11.5 million, over the three year term, avoiding costs of approximately $7.9 million. The Corporation conducted a solicitation via NYS OGS and GSA contracts for the requested software and maintenance for a three year term. EMC Corporation offered the lowest proposed price for the requested services, totaling $3,633,388 over the three year term, resulting in a 68% reduction in the 3 year total spend.

Solicitations were sent out to all eligible vendors on the NYS OGS and GSA contracts and EMC Corporation was selected as the winner based on lowest price.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: VMWARE Enterprise Licensing Agreement (ELA)

Project Title & Number: VMWARE Enterprise Licensing Agreement (ELA)

Project Location: Corporate Data Centers

Requesting Dept.: EITS

Successful Respondent: EMC Corporation

Contract Amount: $3,633,388 plus a 15% contingency of $545,007

Total Not To Exceed Amount: $4,178,395

Contract Term: 3 years

Number of Respondents: 7 respondents
(If Sole Source, explain in Background section)

Range of Proposals:* $3,573,920 to $4,251,520
(* for bundled and unbundled desktop and server virtualization options including an ELA)

Minority Business Enterprise Invited: X Yes If no, please explain:

Funding Source: X General Care Capital
Grant: explain
Other: explain

Method of Payment: X Lump Sum Per Diem Time and Rate
Other: explain 3 annual payments

EEO Analysis: N/A

Compliance with HHC's McBride Principles? X Yes No

Vendex Clearance Yes No X N/A

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

Through this Enterprise License Agreement ("ELA"), HHC is undertaking an important initiative to upgrade our existing infrastructure by virtualizing our critical infrastructure assets. The software provided in the Enterprise Licensing Agreement will enable HHC to effectively service the EPIC implementation, enhance HHC disaster recover capability, enable a private cloud computing environment and securely deploy "Bring Your Own Device (BYOD)."

EITS has recommended the use of virtualized software to support the new EMR/EPIC application as a technical requirement to service the user community's desktops. Virtual desktop infrastructure (VDI) is the practice of hosting a desktop operating system within a virtual machine (VM) running on a centralized server. VDI is a variation on the client/server computing model, sometimes referred to as server-based computing. This configuration builds efficiencies within the infrastructure environment to allow EITS to redirect these support resources to other high level activities.

Server virtualization has many benefits. Server virtualization reduces costs as there is less hardware required. Server virtualization conserves space through consolidation as several machines can be combined into one server running multiple virtual environments. It also utilizes resources to their maximum capacity allowing savings on operational costs (e.g. using a lower number of physical servers reduces hardware maintenance).

Similar to the EPIC deployment, "Bring Your Own Device" (BYOD) must be deployed in a secure, HIPAA compliant environment. By utilizing desktop virtualization, all devices will use a virtual server to access critical applications and files using smartphones, iPad and Android-based tablets and desktops. No files will be stored on these devices, only on the virtualized servers.

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

Presented to the CRC on November 6, 2013.

A portion of the funding for this purchase will be provided from the EMR budget previously presented to the Board of Directors

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:

N/A.

CONTRACT FACT SHEET (continued)

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

EMC Corporation has a NYS OGS Contract (#PT60953). An RFQ to implement desktop virtualization software and maintenance was issued to 17 vendors, who were listed as virtualization software resellers on NYS OGS and GSA contracts.

Three price proposals were received and two "No Bid" responses.

All three proposals were reviewed by HHC IT Infrastructure Services staff to determine whether they met the solicitation requirements. The award was based on lowest proposed price for an Enterprise License Agreement that includes desktop and server virtualization.

List of Firms Considered/Responding to Solicitation

1. EMC Corporation
2. Dell Marketing, L.P.
3. Citrix Systems, Inc.
4. Enpointe
5. Systems Management Planning, Inc.
6. World Wide Technology, Inc.
7. Carahsoft Technology Corp.
8. Infotec, LLC.
9. CDW-Government, Inc.
10. Cerner Corporation
11. Derive Technologies
12. Future Tech Enterprise, Inc.
13. Currier McCabe Associates, Inc. dba/ CMA
14. Dyntek Corporation
15. Ergonomic Group, Inc.

16.Q.E.D. Inc. dba QED National

17.Verizon Network Integration Corp.

CONTRACT FACT SHEET (continued)

Scope of work and timetable:

The accompanying resolution requests approval to enter into a VMWARE Enterprise Licensing Agreement (ELA) with VMWare, Inc., and a contract with EMC Corporation, an authorized reseller of VMWare virtualization software and maintenance, through a NYS Office of General Services (OGS) contract.
The new is for unlimited use of virtual desktop software along with an unlimited amount of monitoring licenses. HHC will be receiving 5000 licenses that will enable HHC to effectively troubleshoot issues in the infrastructure environment, upgrade the existing licenses that allows us to take advantage of new features that were not available with the previous version, receive 400 new licenses that will allow us to continue virtualizing servers over the next three years and training credits to educate HHC on the new technology. HHC will begin the deployment of these licenses as soon as they are secured.

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

Entering into a new ELA for virtual desktops and servers could potentially avoid costs of approximately $7.9 million in monitoring, troubleshooting and virtual desktop licenses over the next three years.

Purchasing each of the items listed in the ELA individually at list price would have cost the Corporation over $11.5 Million dollars over the next three years. We have secured a bid of $3.6M for the same products and support.

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

FY11	$207,178.35
FY12	$425,197.11
FY13	$383,902.72

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

The Work will be done by the Corporation's staff, only the licenses are being purchased from a third party vendor.

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?

NA

CONTRACT FACT SHEET (continued)

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

This contract will be administered by Bert Robles, Senior VP / Corporate CIO.

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):*

N/A

Received By E.E.O. _____
Date

*Analysis Completed By E.E.O.*_____
Date

_____
Name

VMWARE Enterprise License Agreement (ELA)

HHC Board of Directors

January 30, 2014

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

Background Summary

HHC Requirements

- New Enterprise license agreement for virtual desktop and virtual server software and maintenance
- Portion of the Enterprise Licensing agreement is related to EMR Program

Current Scenario

- In 2007, HHC entered into an ELA with Dell for unlimited VMWARE licenses that ended in 2010
- HHC is currently paying for any new server licenses without the benefit of ELA discounts.
- HHC is currently paying maintenance to VMWARE using isolated contracts
- HHC needs desktop virtualization and support software for the new EPIC rollout.
- HHC plans to rollout a corporate virtual desktop environment over the next three years.
- Provide technology to enable “Bring Your Own Device” configurations

ELA Summary

EMC Enterprise Licensing Agreement - New Capabilities

- VMware Horizon View
- VMware vCenter Operations Manager
- VMware vCenter Log Insight
- VMware vCenter Operations 5.6 Management Suite Enterprise
- VMware vCloud Suite 5 Enterprise
- Upgrade: VMware vSphere 5 Enterprise to vSphere 5 Enterprise Plus

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- Training Credits
- Business Critical Service (uplift over Production Support)
- VMware Technical Account Manager (TAM)
- Extended Payment Plan (includes year 3 maintenance)

Financial Analysis

Historical Spend

Description	FY11	FY12	FY13	Total Spend
ELA and Maintenance	$207,178	$425,197	$383,902	$1,016,277

Future Spend *

Description	FY11	FY12	FY13	Total Spend
ELA and Maintenance	$1,293,354	$1,170,017	$1,170,017	$3,633,388

* Approximately $2.1 million is being funded through EMR Capital and Operating Funds

Benefits:

- Reduction in PC refresh requirements (approximately $2M to $4M annually)
- Negotiated volume License + Support & Subscription rates at an 70% discount rate over list price (ability to pay over time)
- $120,000 in Training Service credits
- Business Critical Support included ($80,000 value)
- Technical Account Manager included ($129,900 value)

Procurement Approach

- 17 vendors were solicited via NYS OGS and GSA contracts and 3 bids received for bundled and unbundled desktop and server virtualization options including an ELA
- Below illustrates only bundled pricing received. Single product pricing not shown but is on record through the OGS/GSA solicitation and available for review
- Recommendation: Contract with EMC Corporation, Inc. based on lowest responsive bid for the Enterprise Licensing Agreement
- Contract in an amount not to exceed $4,178,395, which includes a 15% contingency of $545,007 over a three year term).

Vendor Information	Contract	7000 desktop and 400 Server virtualization licenses w/ maintenance	Enterprise License Agreement Bid Amount	No Bid	No Reply
EMC Corporation	NYS OGS	$ 3,573,920	$ 3,633,388		
Dell Marketing, L.P.	NYS OGS	$ 3,989,416	$ 4,222,297		
Citrix Systems, Inc.	NYS OGS	$ 4,251,520			
Enpointe	NYS OGS				X
Systems Management Planning,	NYS OGS			X	
World Wide Technology, Inc.	NYS OGS				X
Carahsoft Technology Corp.	NYS GSA				X
Infotec, LLC.	NYS GSA				X
CDW-Government, Inc.	NYS OGS				X
Cerner Corporation	NYS OGS				X
Derive Technologies	NYS OGS			X	
Future Tech Enterprise, Inc.	NYS OGS				X
Currier McCabe Associates, Inc. dba/ CMA	NYS OGS				X
Dyntek Corporation	NYS OGS				X
Ergonomic Group, Inc.	NYS OGS			X	
Q.E.D. Inc. dba QED National	NYS OGS				X
Verizon Network Integration Corp.	NYS OGS			X	

EMR Budget Presented to Board of Directors in September 2012

The total fifteen-year cost to move from the current state to Epic is outlined below. This includes the cost of the new system as well as the cost to transition off the old systems.

Funding source for Virtualization ELA for hardware

- Approximately $2.1M funding from EMR budget
- Approximately $2M funded from EITS OTPS budget

Component	Description	15-year Cost Presented in September 2012 (in millions)
1. EPIC Contract	Epic Resolution Term 2012-2027	$303
2. QMED	Continuation of current contract through the transition	$80
3. Third Party & other Software *	To be installed over the next 5 years and to be funded through 2027. Includes transition of other existing applications.	$144
4. Hardware*	To be purchased over the next 3 years and replacements to be funded through 2027	$191
5. Interfaces*	To be purchased over the next 3 years and replacements to be funded through 2027	$157
6. Implementation Support*	Vendors to be identified through RFP, Includes cost of non IT Staff participation, training & clinical staff coverage. *(Includes costs associated with backfilling non IT staff with temps.)*	$203
7. Application Support Team	New and Existing HHC Staff to be used through the implementation and maintenance period. (*Includes existing and net new FTEs including fringe benefit costs*)	$ 357
		Total: $1,435

*** Future contracts to be presented to the Board of Directors.**

Questions

Questions?

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to procure and outfit seventy (70) ambulances in Fiscal Year 2014 on behalf of the Fire Department of the City of New York ("FDNY"), through City-wide Requirements Contracts for a total amount not-to-exceed $20.5 million.

WHEREAS, on January 19, 1996, the Corporation and the City of New York (the "City") executed a Memorandum of Understanding ("MOU") allowing the transfer of the Corporation's Emergency Medical Service ("EMS") ambulance and pre-hospital emergency medical service functions to the Fire Department of the City of New York ("FDNY") to be performed by FDNY for the benefit of the City; and

WHEREAS, the MOU requires that the FDNY have access to and use of the Corporation's property to the same extent that EMS had prior to the transfer; and

WHEREAS, a major portion of the Corporation's property used and maintained by the FDNY is the ambulance fleet formerly managed and operated by EMS; and

WHEREAS, to maintain an appropriate ambulance and pre-hospital emergency medical service, vehicles in the ambulance fleet must be periodically replaced when such vehicles have exceeded their useful life, requiring more than routine repairs and maintenance; and

WHEREAS, 70 vehicles out of the FDNY's active fleet of 460 ambulances have reached the end of their useful life and must be replaced at a cost of $20,408,000; and

WHEREAS, the City provides the funding for ambulance replacement to the Corporation for allocation to the FDNY; and

WHEREAS, the City has allocated $58,033,000, on behalf of the FDNY, in the Corporation's Capital Commitment Plan in Fiscal Year 2014 for the purpose of purchasing and outfitting ambulances; and

WHEREAS, sufficient uncommitted funds are available in the Corporation's Fiscal Year 2014 Capital Commitment Plan for this purpose.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and is hereby authorized to procure and outfit seventy (70) ambulances in FY 2014 on behalf of the Fire Department of the City of New York ("FDNY"), through City-wide Requirements Contracts for a total amount not-to-exceed $20.5 million.

EXECUTIVE SUMMARY
EMS AMBULANCES & INITIAL OUTFITTING EQUIPMENT
FISCAL YEAR 2014
FIRE DEPARTMENT OF THE CITY OF NEW YORK

OVERVIEW: The Fire Department of the City of New York ("FDNY") operates the Corporation's Emergency Medical Service ("EMS") program on behalf of HHC under a 1996 Memorandum of Understanding ("MOU"). The MOU requires the FDNY to operate and maintain the City's active fleet of 460 ambulances as part of the EMS program.

As part of the MOU between the Health and Hospitals Corporation and the City of New York, the Corporation collects Medicaid funds for each fee-for-service patient that is admitted to one of its facilities including transports through EMS based on a longstanding agreement between HHC and the New York State Department of Health. Included in the Medicaid funding arrangement with the State DOH is the depreciated value of the ambulances. The Corporation, in turn, reimburses FDNY through payments on a quarterly basis for the provision of ambulance services. The reimbursement represents EMS's pro rata share of Medicaid revenues of which depreciation on the ambulances is included.

NEED: Ambulances have an expected useful life of five (5) years and must be replaced after reaching the five-year period in order to maintain a high-performance fleet. The FDNY has advised the Corporation seventy (70) ambulances ambulances have reached the end of their useful life and need to be replaced. In addition, initial equipment must be purchased to outfit the vehicles for a total acquisition cost of $20,408,000, which includes a ten percent acquisition contingency.

SCOPE: Procurement of seventy (70) ambulances and initial outfitting equipment.

COST: $20.5 million (Non-HHC funds)

FINANCING: New York City General Obligation Bonds (No debt service impact to HHC)

SCHEDULE: FDNY is expected to obtain the ambulances and complete outfitting within 12 months.

The City of New York

FIRE DEPARTMENT

9 METROTECH CENTER BROOKLYN, NY 11201-3857

Robert L. Scott
Director
Bureau of Fiscal Services Room 5W-4

November 25, 2013

Roslyn Weinstein
Senior Assistant Vice President
HHC, Office of Facilities Development
346 Broadway, 12 West
New York, NY 10013

Re: Request for HHC Board Resolution

Dear Ms. Weinstein:

This letter represents a formal submission, to be presented to HHC's Board of Directors at their next meeting. The FDNY hereby requests approval to purchase seventy (70) ambulances of the below descriptions and quantities, plus initial equipment. Detailed initial equipment lists are attached.

Description	# of Units	Unit Price	Total $ Amount
Ambulance F-450 4x2:	35	211,624	7,406,851
Ambulance F-450 4x4:	35	212,824	7,448,851
Inspection fee			25,000
BLS Initial Equipment	49	40,272	1,973,328
ALS Initial Equipment	21	81,005	1,701,105
			18,555,135
		10% contingency:	1,855,514
		Total:	20,410,649

Please be advised that the procurement process is performed in accordance with HHC's operating procedures and Procurement Policy Board rules.

If you require additional information in order to secure HHC board approval, please contact me at 718/999-1221.

Thank you for your cooperation

Sincerely,

Robert L Scott

Robert L. Scott

attch.

c: Stephen G. Rush, FDNY
Mark Aronberg, FDNY
Robin Mundy-Sutton, FDNY
Patricia Mims, FDNY
Terry Fiorentino, FDNY
Dean Moskos, HHC
Jawwad Ahmad, HHC

INITIAL EQUIPMENT FOR ONE (1) FDNY AMBULANCE

MEU BLS READY

EQUIPMENT DESCRIPTION	QTY	COST	EXT
BP UNIT - INFANT	1	$17.35	$17.35
BP UNIT - PEDS	1	$17.35	$17.35
BP UNIT - ADULT	1	$17.35	$17.35
BP UNIT - OBESE	1	$20.90	$20.90
CAN, GARBAGE	1	$12.00	$12.00
CHAIR, STAIR	1	$2,500.00	$2,500.00
CHAIR, STAIR CUSTOM SILK SCREEN	1	$30.00	$30.00
COT, FOLDING W/3 SETS-2PC STRAPS	1	$320.00	$320.00
COT, FOLDING CUSTOM SILK SCREEN	1	$30.00	$30.00
DEFIBRILLATOR KIT, BLS	1	$4,490.10	$4,490.10
MATTRESS, AMB STRETCHER	1	$200.00	$200.00
MATTRESS, CUSTOM SILK SCREEN	1	$30.00	$30.00
OXIMETER KIT, CARBON MONOXIDE	1	$4,390.00	$4,390.00
OXYGEN "D" CYL BRACKET	2	$110.00	$220.00
OXYGEN FLOWMETER	3	$125.00	$375.00
OXYGEN PRESSURE REDUCER	1	$150.00	$150.00
OXYGEN REGULATOR	4	$200.00	$800.00
OXYGEN MONITOR W/2' HARNESS & PLUGS	1	$144.00	$144.00
OXYGEN TRANSDUCER W/2' HARNESS & PLUGS	1	$250.00	$250.00
OXYGEN HARNESS ASSEMBLY 17' W/ PLUGS	1	$37.00	$37.00
SPLINT, TRACTION COMBO	1	$1,000.00	$1,000.00
SPLINT, TRACTION CUSTOM SILK SCREEN	1	$30.00	$30.00
STOOL, STEP	1	$25.00	$25.00
STRETCHER - RAIL	1	$300.00	$300.00
STRETCHER - ROLLING W/3 SETS-2PC STRAPS	1	$4,900.00	$4,900.00
STRETCHER - SCOOP W/3 SETS-2 PC STRAPS	1	$575.23	$575.23
SUCTION UNIT, CHARGING BRACKET	1	$300.00	$300.00
SUCTION UNIT KIT, PORTABLE	1	$815.50	$815.50
SUCTION UNIT, ON-BOARD	1	$322.50	$322.50
		MEU TOTAL	**$22,319.28**

MSU BLS READY

BACKBOARD, LONG	2	$119.84	$239.68
BACKBOARD, SHORT	1	$38.84	$38.84
BAG, BLS DEFIBRILLATOR	1	$73.97	$73.97
BAG, OXYGEN	2	$74.47	$148.94
BAG, TECHNICIAN	2	$146.09	$292.18
BAG, COMPLETE WMD ANTIDOTE	1	$312.98	$312.98
CYLINDER, OXYGEN "D" SIZE	4	$42.00	$168.00
CYLINDER, OXYGEN "M" SIZE	1	$150.00	$150.00
EXTRICATION DEVICE	2	$131.95	$263.90
EXTINGUISHER, 5LB ABC FIRE	2	$38.45	$76.90
LANTERN, 6 VOLT BATTERY	1	$9.77	$9.77
MAP, 5 BOROUGH	1	$35.97	$35.97
POUCH, EPI-PEN	1	$22.79	$22.79
SHOVEL, PLASTIC SNOW	1	$12.01	$12.01
SHOVEL, METAL FOLDING	1	$15.00	$15.00
STRAPS, 9' 1 PC	2	$3.72	$7.43
		MSU TOTAL	**$1,868.36**

BLS READY TOTAL **$24,187.64**

RADIOS			
RADIOS	2	$4,150.00	$8,300.00
HAZMAT			
PD31 METER	2	$350.00	$700.00
CO METERS	2	$300.25	$600.50
RAD57	1	$4,583.00	$4,583.00
DOSIMETERS	2	$950.00	$1,900.00
TOTAL HAZMAT			**$7,783.50**

MEU BLS READY	**$22,319.28**
MSU BLS READY	**$1,868.36**
RADIOS	**$8,300.00**
HAZMAT	**$7,783.50**
[redacted]	

FDNY/EMS MEDICAID REIMBURSEMENT

As part of the Memorandum of Understanding ("MOU") between the Health and Hospitals Corporation (the "Corporation") and the City of New York in regard to the transfer of the ambulance and pre-hospital emergency medical service functions performed by the Emergency Medical Service ("EMS") to the Fire Department of New York (the "FDNY"), the Corporation collects medicaid funds for each medicaid fee-for-service patient that is admitted to one of its facilities as an add-on on the patient's bill to cover the cost of EMS services.

The Corporation calculates the value of the add-ons by multiplying it with the number of patients admitted. A payment is then issued to the FDNY on a quarterly basis. At the last quarter of the fiscal year, the Corporation does a reconciliation exercise and if there is a positive variance, the amount of HHC's fourth payment to the FDNY will be increased by the variance. In the event that the opposite occurs, the fourth payment to the FDNY will be reduced by the difference.

NEW AUTHORIZATION FY 2014

	Unit Price	# of Units	Total	Contingency	Total	Per Unit	$/Equipped Unit
Ambulances (Excluding Initial Equipment):							
Ambulance F-450 4 x 2	211,624	35	7,406,840	$740,684	$8,147,524	$232,786	
Ambulance F-450 4 x 4:	212,824	35	7,448,840	$744,884	$8,193,724	$234,106	
Total Ambulances:		70	14,855,680	1,485,568	16,341,248		
							Type I Ambulances
Initial Equipment for 119 Ambulances:							$277,746 BLS
BLS Initial Equipment	40,272	49	1,973,328	$197,333	$2,170,661	$44,299	$322,552 ALS
ALS Initial Equipment	81,005	21	1,701,105	$170,111	$1,871,216	$89,106	
Total Initial Equipment:		70	3,674,433	$367,443	$4,041,876		
Inspection Fee					$25,000		
Total			18,530,113	$1,853,011	$20,408,124		
Total (Rounded)					$20,408,000		

BLS: Basic Life Support
ALS: Advance Life Support

Past Authorizations FYs 2013, 2012 and FY 2010

FY 2013 Ambulances *
(Revised 7.5.13)

	Unit Price	# of Units	Total	Contingency	Total	Per Unit	$/Equipped Unit
Ambulances (Excluding Initial Equipment):							
Ambulance F-450 4 x 2	198,879	99	19,689,021	$1,968,902	$21,657,923	$218,767	
Ambulance F-450 4 x 4:	200,079	20	4,001,580	$400,158	$4,401,738	$220,087	
Total Ambulances:		119	23,690,601	2,369,060	26,059,661		
							Type I Ambulances
Initial Equipment for 119 Ambulances:							$262,466 BLS
BLS Initial Equipment	38,526	79	3,043,554	$304,355	$3,347,909	$42,379	$307,068 ALS
ALS Initial Equipment	79,074	40	3,162,960	$316,296	$3,479,256	$86,981	
Total Initial Equipment:		119	6,206,514	$620,651	$6,827,165		
Initial Equipment for 77 Ambulances:							$84,757 BLS
BLS Initial Equipment	38,526	52	2,003,352	$200,335	$2,203,687	$42,379	$129,360 ALS
ALS Initial Equipment	79,074	25	1,976,850	$197,685	$2,174,535	$86,981	
Total Initial Equipment:		77	3,980,202	$398,020	$4,378,222		
Total			33,877,317	$3,387,732	$37,265,049		
Total (Rounded)					$37,266,000		

* Fiscal FY13 funding rolled into FY 2014

FY 2012 Ambulances

	Unit Price	# of Units	Total	Contingency	Total	Per Unit	$/Equipped Unit
Ambulances (Excluding Initial Equipment):							
Type I Ambulances:	160,656	80	12,852,480	$1,285,248	$14,137,728	$176,722	
Total Ambulances:		80	12,852,480	$1,285,248	$14,137,728		
							Type I Ambulances
Initial Equipment:							$200,922 BLS
BLS Initial Equipment	22,000	60	1,320,000	$132,000	$1,452,000	$24,200	$227,322 ALS
ALS Initial Equipment	46,000	20	920,000	$92,000	$1,012,000	$50,600	
Total Initial Equipment:		80	2,240,000	$224,000	$2,464,000		
Total			15,092,480	$1,509,248	$16,601,728		
Total (Rounded)					$16,600,000		

FY 2010 Ambulances

	Unit Price	# of Units	Total	Contingency	Total	Per Unit	$/Equipped Unit
Ambulances (Excluding Initial Equipment):							
Type I Ambulances:	155,900	56	8,730,400	$702,833	$9,433,233	$168,451	
Total Ambulances:		56	8,730,400	$702,833	$9,433,233		
							Type I Ambulances
Initial Equipment:							$192,654 BLS
BLS Initial Equipment	22,400	37	828,800	$66,722	$895,522	$24,203	$232,200 ALS
ALS Initial Equipment	59,000	19	1,121,000	$90,245	$1,211,245	$63,750	
Total Initial Equipment:		56	1,949,800	$156,967	$2,106,767		
Total			10,680,200	$859,800	$11,540,000		

MEDICAID FUNDS TRANSFERRED TO THE FDNY

FY	(In millions)
2000	$58.8
2001	$66.2
2002	$63.9
2003	$61.8
2004	$61.9
2005	$55.5
2006	$58.1
2007	$56.7
2008	$56.7
2009	$60.2
2010	$56.9
2011	$59.9
2012	$54.8
2013	$39.5

Source: Martin Genee
Deputy Corporate Comptroller
12/13/13

MEMORANDUM OF UNDERSTANDING

BETWEEN

THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

AND

THE CITY OF NEW YORK

ON THE PROVISION OF AMBULANCE AND PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

BY

THE FIRE DEPARTMENT OF THE CITY OF NEW YORK

FOR THE BENEFIT OF HHC

This Memorandum of Understanding ("MOU"), is made and entered into between the New York City Health and Hospitals Corporation ("HHC") and the City of New York (the "City"), in order to effectuate the transfer of the ambulance and pre-hospital emergency medical service functions performed by the Emergency Medical Service ("EMS") of HHC to the Fire Department of the City of New York (the "FDNY") to be performed by FDNY for the benefit of HHC.

WHEREAS, the parties to this MOU recognize that the availability of high-quality ambulance and pre-hospital emergency medical services is essential to HHC, as the City's public hospital system, and to the health and welfare of all persons in the City of New York; and

WHEREAS, HHC has, until now, operated EMS, which provides ambulance, pre-hospital emergency medical and ancillary services within the City; and

WHEREAS, the personnel and staff of EMS work with great skill, dedication and commitment under difficult circumstances to provide high quality ambulance and pre-hospital emergency medical services; and

WHEREAS, FDNY has completed an operational plan for the performance by FDNY of ambulance, pre-hospital emergency medical and ancillary services now performed by EMS for HHC ; and

WHEREAS, FDNY's operational plan reflects, and the parties believe, that combining EMS's personnel with FDNY's extensive experience operating a highly successful emergency fire response system will result in more effective delivery of ambulance and pre-hospital emergency medical services within the City, benefitting both HHC and the public; and

WHEREAS, the City intends to establish a Bureau of EMS within FDNY to provide ambulance and pre-hospital emergency medical services for HHC and the public; and

WHEREAS, in light of the foregoing, the parties believe that the transfer of EMS functions to FDNY, and the provision of ambulance and emergency services by FDNY to HHC pursuant to agreement, would serve the best interests of the City, the public and HHC; and

WHEREAS, HHC, by resolution of its Board of Directors adopted October 26, 1995, authorized the transfer of functions and the execution of an MOU between the City and HHC setting forth the terms of such transfer; and

WHEREAS, the parties desire by this transfer to enhance the quality, performance and coordination of ambulance and pre-hospital emergency medical services provided within the City;

NOW, THEREFOR, HHC and the City agree as follows:

I. TRANSFER OF FUNCTIONS TO FDNY

1. The parties shall take such steps as are appropriate and necessary in accordance with § 70(2) of the Civil Service Law and this MOU, including obtaining all necessary approvals, to effectuate the transfer to FDNY of ambulance, pre-hospital emergency medical and ancillary functions performed by EMS as set forth in paragraph 6 below ("EMS services").

2. For purposes of this MOU, "transfer date" shall mean the date of the transfer of employees of HHC to FDNY pursuant to paragraph 4 of this MOU.

3. FDNY will establish a Bureau of EMS within FDNY to oversee, direct and command EMS services. The Bureau will be managed by a senior Fire Department staff chief,

the "Chief in Charge, Bureau of EMS" ("EMS Chief"). The EMS Chief or his or her designee will serve as a liaison with HHC.

II. PERSONNEL

4. As soon as practicable after the expiration of the 20-day notice period provided by § 70(2) of the Civil Service Law, the parties shall transfer from HHC to FDNY necessary permanent officers and employees currently assigned to EMS who are substantially engaged in the provision of EMS services ("HHC/EMS employees"), subject to the following:

(a). Such HHC/EMS employees will be transferred to FDNY without change in permanent civil service status, without loss of civil service seniority and with corresponding civil service titles;

(b). Such HHC/EMS employees will be appropriately oriented in relevant FDNY procedures and policies;

(c). The transfer of such HHC/EMS employees will not affect their membership in or rights with respect to the New York City Employees Retirement System.

5. Notwithstanding any other provision of this MOU, Special Officers employed by HHC who are currently assigned to EMS are not necessary officers or employees substantially engaged in the performance of the functions to be transferred, and shall not be transferred, but shall continue to be subject to the jurisdiction of HHC.

III. SERVICES BY CITY AND COMPENSATION BY HHC

6. The City agrees that, effective on the transfer date, FDNY will provide EMS services for the benefit of HHC, including but not limited to:

(a). The performance of ambulance services, directly or through other providers of ambulance services, consistent with the ambulance services provided by EMS prior to the transfer, subject to the limitation set forth in paragraph 7 below;

(b). Emergency inter-facility ambulance transportation for HHC patients to the extent provided immediately prior to the transfer date by personnel of EMS;

(c). The delivery of pre-hospital emergency medical care by qualified personnel;

(d). A central dispatching system to direct and coordinate responses to requests for emergency ambulance and medical services, which shall incorporate all ambulances operated by FDNY, as well as such voluntary and proprietary ambulances as shall choose to participate and be accepted for participation by FDNY;

(e). Any other services necessary to the performance of terms and conditions of federal or state grants, subsidies or other funding;

(f). Support, administrative and personnel services previously provided by personnel of EMS that are necessary to the provision of the services described in subparagraphs (a)-(e) above.

7. After the transfer date, HHC will continue to be responsible for non-emergency inter-facility transports consistent with current practice.

8. In consideration for the provision of EMS services by the City for the benefit of HHC, as set forth in this MOU, HHC will fund the costs of such services, as follows:

(a). HHC will fund the costs of EMS services for the balance of the City's fiscal year 1996 by means of a payment to the City in the amount of $62 million,[1] payable in two equal installments due on April 30, 1996 and June 30, 1996.

(b). Unless the funding arrangements set forth in this subparagraph are modified pursuant to paragraphs 10 or 22 below, HHC will fund the costs of EMS services for each fiscal year after fiscal year 1996 as follows:

(i) The City shall apply $63 million of the HHC subsidy from the City under the New York City Health and Hospitals Corporation Act (Chapter 1016 of the Laws of 1969, as amended) (the "HHC Act") to FDNY as partial payment for the EMS services to be provided by FDNY as set forth in this MOU; and

(ii) HHC, subject to paragraph 9 of this MOU, shall continue to bill for and receive directly all amounts arising from the provision of EMS services by FDNY to patients delivered to HHC hospitals, and prior to the commencement of each fiscal year, the City Budget Director and the President of HHC jointly shall project the amount of collections anticipated by HHC for that fiscal year (the "HHC Projected Collections");

(iii) The amount of the HHC Projected Collections for each fiscal year shall be paid by HHC to the City in four equal payments, subject to adjustment as provided in (iv) and (v) below, with the first three payments to be made on the last day of each of the

[1] This number assumes that the transfer date is March 1,1996. In the event that the transfer occurs on a different date, the President of HHC and the City Budget Director jointly shall determine the appropriate amount.

first three quarters of the fiscal year, and the last payment to be made within 60 days of the end of the fiscal year;

(iv) Within 60 days of the end of each fiscal year, the City Budget Director and the President of HHC jointly shall determine the amount actually collected by HHC for that fiscal year as a result of the operations of EMS (the "HHC Actual Collections"). In the event that the HHC Actual Collections are less than the HHC Projected Collections, the amount of HHC's fourth payment to the City under (iii) above shall be reduced by such difference, provided that HHC exercised diligent efforts, as determined jointly by the City Budget Director and the President of HHC, to maximize the amount of the HHC Actual Collections. In the event that the HHC Actual Collections are in excess of the HHC Projected Collections, the amount of HHC's fourth payment to the City under (iii) above shall be increased by such excess.

(v) Notwithstanding the foregoing, in the event that the President of HHC and the City Budget Director jointly determine that as of the conclusion of the second quarter the HHC projected collections are likely to be materially in excess of the HHC Actual Collections, then the President of HHC and the City Budget Director shall agree to revise appropriately the amount of HHC's third quarter payment to the City under (iii) above.

9. As of the transfer date, the City shall be responsible for the billing and collection of all revenues arising from the provision of EMS services to non-Medicaid patients delivered to hospitals other than those operated by HHC. The revenues collected by the City during fiscal year 1996 shall be remitted to HHC; the revenues collected by the City during subsequent fiscal years shall be retained by the City. Commencing October 1, 1996, the City shall pay HHC a reasonable rate, as determined jointly by the City Budget Director and the

President of HHC, for the billing and collecting of non-Medicaid revenues for EMS services provided to patients delivered to HHC hospitals, or shall assume the responsibility for the billing and collecting of such non-Medicaid revenues. *

10. The Mayor, after consultation with HHC, may modify the funding arrangements set forth in paragraphs 8 and 9 above provided that any such modification does not result in adverse financial consequences for HHC.

11. The parties agree to cooperate with respect to grants and subsidies for EMS services from sources other than the City of New York, as follows:

(a). The parties agree to cooperate in applying for grants and subsidies currently available or which may become available from any source for EMS services, to make best efforts to obtain such funding at a level greater than or equal to the amounts now received and to employ such grants and subsidies as are awarded in a manner consistent with applicable funding conditions;

(b). As soon as practicable, HHC will identify all grants and subsidies authorized by any source for EMS services or for the benefit of EMS; HHC agrees to remit promptly to the City all monies it receives (whether before, on, or after the transfer date) on account of such grants and subsidies to the extent consistent with applicable funding conditions.

12. The City shall provide the following reports to HHC:

(a). Within ninety days after each annual anniversary of the transfer date, FDNY and the City shall report to HHC in writing concerning the services the City has provided pursuant to this MOU. Such report shall include an assessment of the effectiveness of such services, plans for appropriate improvements in such services and quantitative and descriptive information analyzing the level and nature of services.

(b). FDNY and the City will provide such additional reports as HHC reasonably requests in connection with grants, funding, billing or the implementation of this MOU.

13. HHC shall provide the following reports to the City :

(a). Cash receipt reports for EMS services, listing all revenues by source.

(b). Ambulance "drop-off" numbers to HHC hospitals and charges by HHC for:

(i). Medicare patients;

(ii). Self-pay patients;

(iii). Patients covered by third-party insurance.

(c). HHC will provide such additional reports as the City or FDNY reasonably requests in connection with grants, funding, billing or the implementation of this MOU.

IV. PROPERTY AND CONTRACTS OF HHC AND RELATED MATTERS

14. For the purpose of providing EMS services as described in this MOU, as of the transfer date FDNY shall have access to and use of HHC real property to the same extent that EMS had prior to the transfer, including but not limited to EMS stations, outposts and other facilities. In addition, as soon as practicable, HHC shall identify all real property currently used primarily by EMS and all leases or other arrangements relating to such property; the City will review such leases and arrangements and determine, in consultation with HHC, the appropriate treatment of each. Except as otherwise provided for by the parties to this MOU or in leases or other arrangements between HHC and third parties, utilities, maintenance and repairs for the EMS facilities will be provided as follows:

(a). Routine non-structural custodial maintenance of such facilities shall be performed by the City;

(b). Utilities (water, heat, electricity), as well as repairs to structures or fixtures, in facilities also used by HHC for non-EMS purposes (for example, EMS stations located in HHC hospitals) shall be the responsibility of HHC, unless the City elects to undertake the responsibility; and

(c). The City shall be responsible for utilities and repairs to structures or fixtures in other EMS facilities.

15. For the purpose of providing EMS services, as of the transfer date FDNY shall, in its discretion, have access to and use of HHC personal property to the same extent that EMS had prior to the transfer. In addition, as soon as practicable, HHC shall identify all personal property, including but not limited to vehicles and equipment, currently used primarily

by or for the benefit of EMS. In consideration for the services to be provided for the benefit of HHC by the City pursuant to this MOU, HHC shall promptly transfer its interests in such property to the City, to the extent that the City so elects. Such personal property shall, during its useful life, be used to the extent practicable for the purpose of providing ambulance and pre-hospital emergency medical services.

16. As of the transfer date, HHC shall provide to the City, to the extent that the City so elects, all goods or services to be provided under contracts, agreements and other arrangements entered into by HHC for the benefit of EMS, including but not limited to, arrangements with private ambulance services. As soon as practicable, HHC will identify all such contracts, agreements and other arrangements, and the City will review them to determine, in consultation with HHC, the appropriate treatment of each such contract, agreement and arrangement.

V. GENERAL

17. This MOU is not intended, nor shall it be construed, to create any rights or benefits in any third parties.

18. HHC and the City agree that this MOU shall be read consistently with the HHC Act, the New York City Charter and all other applicable federal, State and local laws and regulations.

19. Within a reasonable time after the transfer date, the City shall publish in the *New York Law Journal* an appropriate notice to members of the bar regarding the transfer of EMS functions from HHC to FDNY.

20. The parties shall cooperate: (i) in taking all actions necessary or desirable to implement this MOU, (ii) in exchanging non-privileged information and documentation

relating to EMS services, and (iii) in avoiding adverse financial consequences to either party as a result of the implementation of this MOU.

21. Any disputes between the City and HHC regarding the implementation of this MOU, including but not limited to any disputes between the City Budget Director and the President of HHC regarding payments for services, shall be finally resolved and determined by the City's First Deputy Mayor or such other Deputy Mayor who is designated to sit on HHC's Board of Directors.

22. This MOU may be amended from time to time or terminated by written agreement between the Mayor and the President of HHC.

Agreed to
As of January 19, 1996

Mayor

President, New York City Health and Hospitals Corporation

Approved as to form:

Corporation Counsel