HHC ACO INC.
BOARD OF DIRECTORS
ANNUAL MEETING
November 3, 2014
At 3:00 p.m.
125 Worth Street, 5th Floor Board Room
New York City

AGENDA

CALL TO ORDER — Dr. Ramanathan Raju

OLD BUSINESS

1. Approve and adopt minutes of the HHC ACO Inc. ("ACO") Board of Directors meeting held on August 14, 2014 (Exhibit A)

NEW BUSINESS

1. RESOLUTION authorizing that the following persons be elected to serve in the offices of the ACO as set forth below, 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
Ramanthan Raju, M.D.	Chairman
Ross M. Wilson, M.D.	Chief Executive Officer
Marlene Zurack	Treasurer
Salvatore J. Russo	Secretary

2. RESOLUTION authorizing that the number of Directors of the ACO's Board of Directors be fixed at ten (10), subject to approval by the Centers for Medicare and Medicaid Services ("CMS") of a Director to be named by New York University School of Medicine ("NYU");

AND

Authorizing, upon such CMS approval, that a person to be named by NYU, as specified in a writing by NYU that is delivered to the Chairman of the ACO, is hereby elected to serve as an additional Director of the ACO'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 ratification by the ACO's sole Member, the New York City Health and Hospitals Corporation ("HHC")

3. REPORT by Chief Executive Officer Ross M. Wilson, M.D. on the ACO's activities and matters related to the allocation of shared savings

4. RESOLUTION authorizing the ACO to distribute the 2013 Performance Payment as described in the Shared Savings Allocation Report (Exhibit B), with the intent that such payments be used to further the ACO's goals of improving quality and reducing overall cost of care, and for distribution to the physicians providing direct primary care to the ACO patient population

5. DISTRIBUTION of *Acknowledgement of Fiduciary Duties and Responsibilities* to be signed by each Board Member (Exhibit C-1), applicable State law (Exhibit C-2), and excerpt from ACO Certificate of Incorporation describing its mission (Exhibit C-3)

ADJOURNMENT **Dr. Ramanathan Raju**

EXHIBIT A

HHC ACO INC.
MINUTES OF THE
BOARD OF DIRECTORS MEETING
August 14, 2014
125 Worth Street, 5th Floor
Board Room
New York City

ATTENDEES

BOARD MEMBERS

Jeromane Berger-Gaskin
Balavenkatesh Kanna, M.D.
Luis R. Marcos, M.D.
Antonio D. Martin
Jasmine Moshirpur, M.D.
Ramanathan Raju, M.D.
Ross Wilson, M.D.

HHC STAFF

Nancy Barnicle
Megan Cunningham
Mark Hartman
Randall Mark
Nicholas Stine, M.D.
Jay Weinman

CALL TO ORDER

The meeting of the Board of Directors of HHC ACO Inc. ("Board") was called to order by Ross Wilson, M.D., CEO of HHC ACO Inc. ("ACO"), at 2:36 p.m. Dr. Wilson explained that Alan D. Aviles, the former Chair of the ACO, was no longer with the New York City Health & Hospitals Corporation ("HHC"), and so Dr. Wilson would lead the meeting until the incoming Chair was appointed.

Dr. Wilson invited Board members and other meeting attendees to introduce themselves. HHC Senior Counsel Mark Hartman and HHC Corporate Comptroller

Jay Weinman were identified as attending on behalf of Board members Salvatore Russo and Marlene Zurack, respectively. Dr. Wilson noted that the faculty practice plans that provide services in HHC facilities are Participants in the ACO and have access to the Board. Dr. Balavenkatesh Kanna represents the collective view of the four PAGNY faculty practice plans and Dr. Jasmine Moshirpur represents the Mt. Sinai Elmhurst faculty practice plan. The ACO will also invite an affiliate representative from NYU to attend Board meetings, to foreshadow a more formalized role for NYU in the future.

OLD BUSINESS

Dr. Wilson entertained a motion to adopt the minutes of the November 6, 2013 meeting of the Board. A motion was duly made and seconded. There being no corrections to the minutes offered by the members of the Board, the motion to adopt the minutes was unanimously approved.

NEW BUSINESS

The first item on the Agenda was consideration of a series of Resolutions that would conclude the term of Alan D. Aviles as Director and Chair of the Board, and elect Dr. Raju as his successor. A motion was made and duly seconded to adopt the Resolutions identified as number one on the Agenda:

> 1. RESOLUTION authorizing, pursuant to § 4.11 of the Amended and Restated By-laws of the Corporation (the "By-laws"), that Alan D. Aviles, due to the conclusion of his term as President of the New York City Health and Hospitals Corporation ("HHC") on March 31, 2014, conclude his term as a Director of the Corporation as of that date, subject to approval and ratification by HHC;
>
> AND
>
> Authorizing, pursuant to § 5.10 of the By-laws, that Alan D. Aviles, due to the conclusion of his term as President of HHC as of March 31, 2014, conclude his term as the Corporation's Chairman of the Board as of that date;
>
> AND
>
> Authorizing, pursuant to § 4.13 of the By-laws, that Ramanathan Raju, M.D. be elected to serve as a Director of the Corporation as of March 31, 2014, as successor to Alan D. Aviles, due to Dr. Raju's employment as President of HHC as of that date, subject to approval and ratification by HHC;
>
> AND

> Authorizing, pursuant to § 5.02 of the By-laws, that Ramanathan Raju, M.D. be elected to serve as the Corporation's Chairman of the Board as of March 31, 2014, as successor to Alan D. Aviles, due to Dr. Raju's employment as President of HHC as of that date.

There was no further discussion of the motion. The motion was unanimously approved, and Dr. Wilson turned the meeting over to Dr. Raju as new Board Chair.

The next item was consideration of a Resolution to amend the ACO By-laws. A motion was made and duly seconded to adopt the Resolution identified as number two on the Agenda:

> 2. RESOLUTION approving and adopting amended and restated By-laws of the Corporation (Exhibit B), modifying Article 4 (Directors) and Article 5 (Officers), subject to approval and ratification by HHC, the Corporation's sole Member.

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

The following item was consideration of a Resolution authorizing an auditing firm to provide services to the ACO. A motion was made and duly seconded to adopt the Resolution identified as number three on the Agenda:

> 3. RESOLUTION authorizing KPMG LLP ("KPMG") to provide the Corporation with auditing services and other directly related services for a term of four (4) years, as set forth in a Resolution approved by the Board of Directors of HHC on April 24, 2014 (Exhibit C).

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

The next agenda item was a report from the Chief Executive Officer of the ACO, Dr. Wilson. Dr. Wilson acknowledged the Director of Operations Megan Cunningham and Chief Medical Officer Nicholas Stine for their work on behalf of the ACO and in preparation for the Board meeting.

Dr. Wilson began his report with a review of high-level issues related to ACO operations. The ACO participates in the Medicare Shared Savings Program ("MSSP"), a three-year program focused on improving care for Medicare Fee For Service patients. The ACO is currently in the second year of the program, roughly halfway through its contract with the Centers for Medicare & Medicaid Services

("CMS"). In that time, the ACO has developed effective IT, governance, and operational infrastructure, and satisfied CMS requirements. For the remainder of 2014 and in 2015, the ACO will focus on how to implement various strategies to improve quality measures and coordination of care.

About 12,500 patients are currently attributed to the ACO. The number of ACO-assigned beneficiaries changes by quarter, and in fact fluctuates quite a bit over time. The most recent attribution figures include Elmhurst patients, since Mt. Sinai created a new tax identification number for its faculty practice plan.

The majority of the ACO's patients are dual eligible and the population has a high rate of major psychiatric, HIV/AIDS, and chronic disease diagnoses. The ACO's population is very different from the rest of the country, with implications for care, care coordination, and quality performance.

Dr. Wilson raised the question of how to leverage the ACO in the Delivery System Reform Incentive Payment program ("DSRIP") and expand the ACO to other non-Medicare patients, particularly Medicaid. The ACO is actively participating in a State workgroup to consider Medicaid ACO models.

Dr. Wilson indicated that the ACO is interested in learning more about patient attrition; for instance, where are the patients who leave the ACO going? This information can be gleaned from claims data, which the ACO receives monthly from CMS. In Q1 2013, the ACO lost 1,787 patients, of which a small number died; one-third had a plurality of their primary care outside of HHC and moved providers; one-third enrolled in Medicare Advantage; and the remaining third did not see any provider during the prior year. This final group is amenable to engagement strategies that provide enhanced access to primary care.

Dr. Wilson next presented on the ACO's quality metrics, and noted that the current data is embargoed by CMS until further notice. The ACO is performing well in medication reconciliation, falls risk screening, health promotion and education, and so forth. Performance is less strong in tobacco non-use, the diabetes composite (although the ACO does well in diabetes measures individually), heart failure admissions, and the attestation of physicians as part of Meaningful Use activity.

Dr. Raju questioned why the tobacco non-use measure scores are low, given the long-standing emphasis on cessation programs at HHC. Dr. Wilson explained that this points to a known issue: patients with access to tobacco cessation programs receive good care, but a number of groups are not being referred from primary

care. HHC is changing its internal quality indicators to better track this issue and modifying the workflow to simplify referrals. As such, Dr. Wilson expects to see improvement in another six months' time.

Dr. Raju indicated concern about performance in shared decision making. Dr. Wilson responded that the patient satisfaction indicators come from the ACO CAHPS survey, and reflect the patients' view that they are not involved enough. HHC has room to improve patient engagement in care, and this will be a priority going forward.

Dr. Moshirpur mentioned the challenge that tobacco cessation supports were not previously available in all clinics at Queens. The medical board recently decided that nicotine replacement therapy must be made more widely available, and with sufficient supply. Dr. Raju replied that HHC has spent millions of dollars on cessation, but unless this is viewed as standard routine, rather than a "project," gains are not sustained. Mr. Martin pointed out that HHC used to receive cessation materials at no cost, but now that HHC must pay for nicotine replacement therapy the supply is limited outside of primary care. Dr. Wilson added that pharmacies are now requiring a prescription from the doctor, which is another barrier to getting the therapies into patients' hands.

Dr. Wilson next presented the case summary of a single ACO patient to demonstrate the power of having access to Medicare claims data. This patient first came to Woodhull in April 2013. He was a high-utilizer with COPD and other complicated issues. The patient was discharged from Woodhull to a skilled nursing facility, Ditmas Park. When he decompensated, the patient was taken to University Hospital in Brooklyn and eventually discharged back to Ditmas Park. Over the course of several months, the patient bounced among five hospitals and two nursing facilities before the end of his life. The patient received full workups everywhere and experienced many transitions.

With only HHC internal data, it is impossible to track this type of utilization. Claims data allows the ACO to see across healthcare settings, and findings like this underscore the importance of coordination and communication. Patients often move around the system in uncomfortable, unsympathetic ways. Dr. Raju suggested the reason for cases like this one is a "greedy" healthcare system, where the patient is a currency. Mr. Martin spoke about the importance of linking patients to an accountable provider.

Dr. Wilson mentioned some of the questions this case raises, such as: Why did no one talk to Woodhull? What was the communication mechanism? How did HHC handle the discharge? The case highlights systemic issues. The ACO is accountable for all of the Medicare expenditures associated with the patient, even though HHC only provided a small fraction of the care. The ACO has a clinical and humane interest, as well as a financial interest, in helping Fee For Service patients navigate the system. Dr. Wilson wondered whether, if this were a managed care patient, the outcome would have been different? The Fee For Service environment promotes uncoordinated care.

Dr. Wilson explained that the ACO is addressing these issues by focusing on high-risk patients, the 5 to 10% of patients who have complicated care needs. The ACO is learning more about how to identify such patients in advance by using claims data and electronic medical record triggers, then deploying a variety of interventions. The ACO is working with NYU Professor John Billings on predictive modeling to flag high-risk patients and get them into a complex care coordination system to prevent deterioration.

Dr. Wilson then reviewed a snapshot of the data that drives ACO interventions. Chief Medical Officer Dr. Nicholas Stine designed a dashboard for facilities and clinical groups to use. Each facility has an ACO clinical lead and the ACO reports strong engagement and leadership across HHC. Dr. Stine and Director of Operations Megan Cunningham spend a good deal of time working with the sites to help them better understand their role and why it is important, both for the ACO and chronic illness care at HHC more generally.

Overall, the ACO scored at about the 74th percentile nationally for the clinical quality measures it reported to CMS. For 2013, the ACO received full credit for reporting in a complete and accurate manner. If the ACO is able to save money, after taking into account ACO overhead expenses, then there could be potential funds for distribution amongst the participants proportional to the number of their covered lives. Financial performance information is not expected from CMS until the fall.

Dr. Marcos asked if there were financial implications for dual eligible beneficiaries as compared to non-duals. Dr. Wilson responded there was not with respect to the ACO, but as for revenue to HHC the answer could be yes, depending on who is providing care.

Dr. Marcos asked whether care managers were assigned to specific patients. Dr. Wilson distinguished case management, care management, and care coordination,

explaining that there are individual roles for each of those functions. HHC views case management as a Patient-Centered Medical Home ("PCHM") team function. Only the very intense patients will have a care manager because they need help navigating the healthcare system. The care manager is part of the Health Home, the structure by which HHC proactively manages the most complicated patients. Patients with behavioral health diagnoses, chronic illnesses, homelessness, etc., all present with different needs, and HHC must be responsive to each.

Dr. Marcos reminded the Board that in the 1990s New York State developed an intense, sophisticated program for mental health to address "heavy users." Each patient was assigned to a case manager. The ratio of 15 patients per case manager was too expensive, so the State kept increasing the number of patients assigned.

Dr. Wilson explained that is exactly the Health Home model, which followed the CIDP program. Now Health Home is paid for a ratio of one care manager to 60 patients. TCM, COBRA, and other legacy programs were rolled into Health Home, and HHC had to migrate patients accordingly. This saves the State money, since under legacy programs the per member per month payment was significantly higher. HHC is exploring IT solutions and other options to make the Health Home model work more efficiently.

Ms. Berger-Gaskin questioned whether all HHC hospitals have an associated sub-acute facility, like the relationship between Kings County and Dr. Susan Smith McKinney. Dr. Wilson replied that the expectation is HHC hospitals will investigate access to HHC's long-term care facilities before sending a patient outside of the system. However, claims data shows that the majority of patients in the ACO who need long-term care and home care services are being referred outside of HHC.

Dr. Mosphirpur asked whether HHC has enough long-term care facilities to serve 11 acute care hospitals. Dr. Wilson explained that the majority of patients in HHC long-term care facilities are not referred from HHC, so HHC must be underutilizing them. Mr. Martin agreed that HHC is not a feeder as it should be. Dr. Moshirpur commented that often patients have long hospital stays and cannot be discharged because sub-acute facilities refuse to take them, especially if they are undocumented.

Dr. Raju suggested that HHC's workforce is not completely connected to the financial viability of the organization, so more should be done to inculcate them. Historically, this has been a problem because HHC was a highly federated

structure rather than an integrated system. That time is coming to an end, in part because of the ACO.

Dr. Wilson concluded his report by summarizing that the ACO's data is shining a light on a number of issues and will pose important questions for management.

ADJOURNMENT

There being no further business, Dr. Raju adjourned the meeting at 3:24 p.m. *sine die.*

Respectfully submitted,

Ross M. Wilson

Acknowledged and Approved by

Salvatore J. Russo
Secretary

Adopted _____

EXHIBIT B

HHC Accountable Care Organization
Shared Savings Allocation Report

Background

As an Accountable Care Organization in the Medicare Shared Savings Program (MSSP) with a January 1st, 2013 start date, the HHC Accountable Care Organization (HHC ACO) was recently notified of its year one performance results. By successfully meeting cost and quality targets, the HHC ACO will receive a performance payment of $3,639,753 from the Centers for Medicare and Medicaid Services (CMS).

CMS Performance Payment Calculation	
Assigned Beneficiaries	12,369
Per Capita Expenditures - Benchmark	$8,993
Per Capita Expenditures - Actual	$8,373
Total Expenditures - Benchmark	$107,675,547
Total Expenditures - Actual	$100,247,480
Total Savings	**$7,428,094**
Quality Score	100%
Final Sharing Rate	**50.0%**
Shared Savings	$3,714,047
Sequestration Adjustment	$74,281
Earned Performance Payment	**$3,639,766**

Savings Distribution Methodology

HHC ACO agreements with HHC and Participants/Affiliates set out the following framework for savings distribution using a stepwise methodology:

1. Reimburse all reasonable and customary costs incurred in establishing the ACO
2. Any remaining shared savings allocated:
    - **50% to HHC**
    - **50% to Participants/Affiliates** in proportion to the percentage of beneficiaries receiving services from Participant/Affiliate employed physicians at HHC facilities, for distribution to the physicians

Allocating the $3,639,766 performance payment according to this methodology yields the following breakdown:

Total 2013 Earned Performance Payment	$3,639,766
ACO Startup Investment Reimbursement*	$1,219,834
HHC Share**	$1,209,966
Participant/Affiliate Share***	$1,209,966

* Includes all FY 2014 ACO expenses. See Appendix A for Itemized Budget.
** Includes HHC employed physicians.
*** Includes Coney Island Medical Practice Plan, P.C. ("CIMPP"); Downtown Bronx Medical Associates, P.C. ("DBMA"); Harlem Medical Associates, P.C. ("HMA"); Metropolitan Medical Practice Plan, P.C. ("MMPP"); Physician Affiliate Group of New York, P.C. ("PAGNY"), for physicians providing services at Jacobi Medical Center and North Central Bronx Hospital ("North Bronx"); Icahn School of Medicine at Mount Sinai, doing business as The Mount Sinai Services Queens Hospital Center ("Sinai-Queens"); and New York University School of Medicine ("NYU"). Does not include the Mount Sinai Elmhurst Faculty Practice Group, which was added as HHC ACO Participant in 2014.

HHC Share
The HHC share of performance payment shall be invested to create infrastructure for the delivery of high-quality patient-centered care to further the ACO's goals of improving quality and reducing overall cost of care at HHC, including support for HHC-employed physicians and tools for improving primary care and population management capacity and access.

Participant/Affiliate Share
To be distributed to physicians in proportion to the provision of care to beneficiaries across HHC. Primary care attribution was determined from a detailed analysis of claims for 2013 assigned ACO beneficiaries:

Facility	2013 Attributed ACO Patients*
Bellevue	1550
Belvis	100
Coney	1023
Cumberland	133
East NY	140
Gouverneur	1004
Harlem	638
Jacobi	1319
Kings	1440
Lincoln	1262
Metropolitan	927
Morrisania	28
North Central Bronx	398
Queens	966
Renaissance	108
Sea View	172
Woodhull	1008
Total	**12216**

*Excludes patients unable to assign (153 total)

Since performance payments are distributed by the ACO at the level of Participant/Affiliate, the total $1,209,966 payment is apportioned based on the employer of each facility's primary care physicians as follows:

	PAGNY					Other Affiliates		
	CIMPP	**DBMA**	**HMA**	**MMPP**	**North Bronx**	**NYU**	**Sinai - Queens**	**Total**
% of ACO PCPs	10%	14%	8%	10%	19%	28%	11%	100%
Share of Payment	$121,334	$172,226	$94,465	$123,691	$229,102	$340,260	$128,893	$1,209,966

See Appendix B for detailed breakdown of Participant/Affiliate share by facility.

Distribution to Physicians

The full amount of earned performance payments are to be distributed by Participant/Affiliates directly to provider physicians. The foundation of success in achieving better health, better care, and lower costs under the ACO model is the delivery of robust patient-centered primary care, and as such it is recommended that the ACO performance payments should be distributed to the physicians providing direct primary care to the ACO patient population.

At the discretion of the primary care providers, it may also be appropriate for these providers to establish a governance process for investing performance payment funds in alternative ways than provider payments, provided that these investments clearly further the population health goals of the ACO.

Appendix A: ACO FY 2014 Budget

NEW YORK CITY HEALTH AND HOSPITALS CORP

Expenses incurred by the HHC ACO
FY 2014

Expense Description	Cost Center	% to be charged to ACO	8010100 Salary	8210100 Fica	8211100 Medicare	8250100 Pension	8230100 Health	8270100 Welfare	8293100 OPEB	8890100 OTPS	8330100 EITS Consultants	8340100 Legal	8751100 IT	Total
ACO Personnel Services	6611	100%	320,399	20,804	4,865	30,762	41,395	9,281	21,908					449,414
IT Personnel Services	6611	100%	160,339	9,941	2,325	18,715	20,716	4,645	15,376					232,057
OTPS Expenses	6611	100%								45,769				45,769
EITS Consultants	6611	100%									129,430			129,430
Legal Services	6611	100%										296,164		296,164
IT / Health Endeavors	6611	100%											67,000	67,000
		TOTAL	**480,738**	**30,745**	**7,190**	**49,477**	**62,111**	**13,926**	**37,285**	**45,769**	**129,430**	**296,164**	**67,000**	**1,219,834**

Notes

1. Central Office FY '14 fringe rate is 34.53% excluding OPEB.
2. Total fringe benefits are $163,448, excluding OPEB.
3. OPEB based on FY '13 figures.
4. Accounting services were immaterial, and therefore, were not included as part of the ACO expenses for FY '14.
5. Difference in fringe rates between Central Office and NYU was immaterial, and thus, Central Office rate was used to calculate the fringe benefits for the affiliate.

Appendix B: Participant/Affiliate Share Calculation

PCP Employer Breakdown by Facility:

Facility	2013 Attributed ACO Patients	PCP Employer			
		HHC	PAGNY	NYU	Mt Sinai
Bellevue	1550	17%		83%	
Belvis	100	78%	22%		
Coney	1023	11%	89%		
Cumberland	133			100%	
East NY	140	100%			
Elmhurst	0	3%			97%
Gouverneur	1004	88%		12%	
Harlem	638		100%		
Jacobi	1319		100%		
Kings	1440	100%			
Lincoln	1262		100%		
Metropolitan	927		100%		
Morrisania	28	75%	25%		
North Central Bronx	398		100%		
Queens	966				100%
Renaissance	108	35%	65%		
Sea View	172	100%			
Woodhull	1008			100%	
Total	**12216**				

Participant/Affiliate Share by Facility*:

Facility	2013 Attributed ACO Patients	PAGNY					Other Affiliates		Total
		CIMPP	DBMA	HMA	MMPP	North Bronx/ PAGNY	NYU	Mt. Sinai	
Bellevue	1550	$-	$-	$-	$-	$-	$171,277	$-	$171,277
Belvis	100	$-	$2,901	$-	$-	$-	$-	$-	$2,901
Coney	1023	$121,334	$-	$-	$-	$-	$-	$-	$121,334
Cumberland	133	$-	$-	$-	$-	$-	$17,747	$-	$17,747
East NY	140	$-	$-	$-	$-	$-	$-	$-	$-
Gouverneur	1004	$-	$-	$-	$-	$-	$16,746	$-	$16,746
Harlem	638	$-	$-	$85,129	$-	$-	$-	$-	$85,129
Jacobi	1319	$-	$-	$-	$-	$175,996	$-	$-	$175,996
Kings	1440	$-	$-	$-	$-	$-	$-	$-	$-
Lincoln	1262	$-	$168,391	$-	$-	$-	$-	$-	$168,391
Metropolitan	927	$-	$-	$-	$123,691	$-	$-	$-	$123,691
Morrisania	28	$-	$934	$-	$-	$-	$-	$-	$934
NCB	398	$-	$-	$-	$-	$53,106	$-	$-	$53,106
Queens	966	$-	$-	$-	$-	$-	$-	$128,893	$128,893
Renaissance	108	$-	$-	$9,336	$-	$-	$-	$-	$9,336
Sea View	172	$-	$-	$-	$-	$-	$-	$-	$-
Woodhull	1008	$-	$-	$-	$-	$-	$134,503	$-	$134,503
Total	**12216**	**$121,334**	**$172,226**	**$94,465**	**$123,691**	**$229,102**	**$340,273**	**$128,893**	**$1,209,966**

*Does not include HHC employed physicians.

EXHIBIT C-1

Acknowledgement of Fiduciary Duties and Responsibilities

As a member of the HHC ACO Inc. ("Corporation") Board of Directors, I understand that I have a fiduciary obligation to perform my duties and responsibilities to the best of my abilities, in good faith and with proper diligence and care, consistent with the enabling statute, mission, and by-laws of the Corporation and the laws of New York State. As a member of the Board of Directors:

I. Mission Statement

I have read and understand the mission of the Corporation; and the mission is designed to achieve a public purpose on behalf of the State of New York. I further understand that my fiduciary duty to this Corporation is derived from and governed by its mission.

I agree that I have an obligation to become knowledgeable about the mission, purpose, functions, responsibilities, and statutory duties of the Corporation and, when I believe it necessary, to make reasonable inquiry of management and others with knowledge and expertise so as to inform my decisions.

II. Deliberation

I understand that my obligation is to act in the best interests of the Corporation and the People of the State of New York whom the Corporation serves. I agree that I will exercise independent judgment on all matters before the board.

I understand that any interested party may comment on any matter or proposed resolution that comes before the board of directors consistent with the laws governing procurement policy and practice, be it the general public, an affected party, a party potentially impacted by such matter or an elected or appointed public official. However, I understand that the ultimate decision is mine and will be consistent with the mission of the Corporation and my fiduciary duties as a member of the Corporation's board of directors.

I will participate in training sessions, attend board and committee meetings, and engage fully in the board's and committee's decision-making process.

III. Confidentiality

I agree that I will not divulge confidential discussions and confidential matters that come before the board for consideration or action.

IV. Conflict of Interest

I agree to disclose to the board any conflicts, or the appearance of a conflict, of a personal, financial, ethical, or professional nature that could inhibit me from performing my duties in good faith and with due diligence and care.

I do not have any interest, financial or otherwise, direct or indirect, or engage in any business or transaction or professional activity or incur any obligation of any nature, which is in substantial conflict with the proper discharge of my duties in the public interest.

Signature: _____ Date: _____

Print Name: _____

Director, HHC ACO Inc.

EXHIBIT C-2

McKinney's Public Authorities Law § 2824

MCKINNEY'S CONSOLIDATED LAWS OF NEW YORK ANNOTATED
PUBLIC AUTHORITIES LAW
CHAPTER 43-A OF THE CONSOLIDATED LAWS
ARTICLE 9--GENERAL PROVISIONS
TITLE 2--BOARDS OF PUBLIC AUTHORITIES

Current through L.2013, chapters 1 to 56 and 60 to 66.

§ 2824. Role and responsibilities of board members

1. Board members of state and local authorities shall (a) execute direct oversight of the authority's chief executive and other management in the effective and ethical management of the authority; (b) understand, review and monitor the implementation of fundamental financial and management controls and operational decisions of the authority; (c) establish policies regarding the payment of salary, compensation and reimbursements to, and establish rules for the time and attendance of, the chief executive and management; (d) adopt a code of ethics applicable to each officer, director and employee that, at a minimum, includes the standards established in section seventy-four of the public officers law; (e) establish written policies and procedures on personnel including policies protecting employees from retaliation for disclosing information concerning acts of wrongdoing, misconduct, malfeasance, or other inappropriate behavior by an employee or board member of the authority, investments, travel, the acquisition of real property and the disposition of real and personal property and the procurement of goods and services; (f) adopt a defense and indemnification policy and disclose such plan to any and all prospective board members; (g) perform each of their duties as board members, including but not limited to those imposed by this section, in good faith and with that degree of diligence, care and skill which an ordinarily prudent person in like position would use under similar circumstances, and may take into consideration the views and policies of any elected official or body, or other person and ultimately apply independent judgment in the best interest of the authority, its mission and the public; **(h) at the time that each member takes and subscribes his or her oath of office, or within sixty days after the effective date of this paragraph if the member has already taken and subscribed his or her oath of office, execute an acknowledgment, in the form prescribed by the authorities budget office after consultation with the attorney general, in which the board member acknowledges that he or she understands his or her role, and fiduciary responsibilities as set forth in paragraph (g) of this subdivision, and acknowledges that he or she understands his or her duty of loyalty and care to the organization and commitment to the authority's mission and the public interest.**

(Emphasis added.)

EXHIBIT C-3

Excerpt From HHC ACO Inc. Certificate of Incorporation:

FOURTH: I. The purposes for which the Corporation is formed are as follows:

(a) Engaging in the business of an Accountable Care Organization ("ACO") that will seek to reduce fragmentation of healthcare delivery, improve health, and lower overall growth in healthcare expenditures. As an ACO, the Corporation will promote accountability for a designated patient population, coordinate services furnished by ACO participants, and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery. The ACO and its participants will agree to become accountable for the quality, cost, and overall care delivered to its designated patient population. The Corporation may share among its ACO participants savings generated by the Corporation for its ACO activities.

RESOLUTIONS

RESOLUTION OF HHC ACO INC. ("ACO")

Authorizing that the following persons be elected to serve in the offices of the ACO as set forth below, 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**
Ramanathan Raju, M.D.	**Chairman**
Ross M. Wilson, M.D.	**Chief Executive Officer**
Marlene Zurack	**Treasurer**
Salvatore J. Russo	**Secretary**

WHEREAS, the Bylaws of the ACO state that officers shall be elected by the ACO's Board of Directors (the "Board") and hold office for a term of one year and until such Officer's successor has been elected or appointed and qualified; and

WHEREAS, the Board last elected officers on November 6, 2013, and now desires to elect new officers, who will supersede the officers heretofore elected and shall be authorized, empowered, and directed to take all steps necessary to effectuate the purposes specified in the ACO's Certificate of Incorporation.

NOW, THEREFORE, BE IT

RESOLVED, that that the following persons are hereby elected to serve in the offices of the ACO as set forth below, 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**
Ramanathan Raju, M.D.	Chairman
Ross M. Wilson, M.D.	Chief Executive Officer
Marlene Zurack	Treasurer
Salvatore J. Russo	Secretary

RESOLUTION OF HHC ACO INC. ("ACO")

Authorizing that the number of Directors of the ACO's Board of Directors be fixed at ten (10), subject to approval by the Centers for Medicare and Medicaid Services ("CMS") of a Director to be named by NEW YORK UNIVERSITY SCHOOL OF MEDICINE ("NYU");

AND

Authorizing, upon such CMS approval, that a person to be named by NYU, as specified in a writing by NYU that is delivered to the Chairman of the ACO, is hereby elected to serve as an additional Director of the ACO'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 ratification by the Corporation's sole Member, the New York City Health and Hospitals Corporation ("HHC").

WHEREAS, the ACO previously appointed certain individuals to serve as the ACO's Board of Directors, as specified in the ACO's Certificate of Incorporation and subsequent Resolutions, and now desires to fix the number of Directors at ten (10), subject to approval by CMS of a Director to be named by NYU and ratification by HHC's Board of Directors; and

WHEREAS, the ACO is required by the Medicare Shared Savings Program ("MSSP") regulations to notify CMS if the ACO's Board of Directors will include less than seventy-five percent (75%) Participant control; and

WHEREAS, NYU employed physicians do not bill Medicare for services provided in HHC facilities and therefore NYU does not qualify as an ACO Participant as defined by the MSSP regulations, and as such the addition of a Director representing NYU would result in less than seventy-five percent (75%) percent Participant control of the ACO's Board of Directors; and

WHEREAS, NYU employed physicians contribute to the ACO's overarching goals of delivering better care at lower cost for ACO attributed patients who receive services at HHC facilities, and NYU entered into an Agreement with the ACO that requires NYU to comply with MSSP regulations.

NOW, THEREFORE, BE IT

RESOLVED, that the ACO authorizes the number of Directors of the ACO's Board of Directors to be fixed at ten (10), subject to approval by CMS of a Director to be named by NYU; and

BE IT FURTHER RESOLVED, that upon such CMS approval, the person specified in a writing by NYU that is delivered to the Chairman of the ACO is hereby elected to serve as an additional Director of the ACO'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 HHC.

RESOLUTION OF HHC ACO INC. ("ACO")

Authorizing the ACO to distribute the 2013 Performance Payment as described in the Shared Savings Allocation Report (Exhibit B), with the intent that such payments be used to further the ACO's goals of improving quality and reducing overall cost of care, and for distribution to the physicians providing direct primary care to the ACO patient population.

WHEREAS, the ACO is a participant in the Medicare Shared Savings Program ("MSSP"), which rewards ACOs that lower their growth in Medicare health care costs while meeting performance standards on quality of care; and

WHEREAS, the ACO in its first Performance Year (2013) successfully reported on all MSSP quality measures and reduced the total Medicare expenditures for its attributed patient population, and thereby earned a Performance Payment in the amount of $3,639,766; and

WHEREAS, the 2013 Performance Payment distribution methodology and how such payments shall be expended is set forth in Agreements between the ACO and, respectively, the New York City Health & Hospitals Corporation ("HHC"); Coney Island Medical Practice Plan P.C., Downtown Bronx Medical Associates P.C., Harlem Medical Associates P.C., Metropolitan Medical Practice Plan, P.C., and Physician Affiliate Group of New York; Icahn School of Medicine at Mount Sinai, doing business as The Mount Sinai Services Queens Hospital Center; and New York University School of Medicine (collectively the "Participants and Affiliates"); and

WHEREAS, the Shared Savings Allocation Report (Exhibit B) applies the distribution methodology to calculate the Performance Payment amounts due to HHC, Participants and Affiliates, and describes the intended use of such payments to further the ACO's goals of improving quality and reducing overall cost of care, and for distribution to the physicians providing direct primary care to the ACO patient population.

NOW, THEREFORE, BE IT

RESOLVED, that the ACO is hereby authorized to distribute the 2013 Performance Payment as described in the Shared Savings Allocation Report (Exhibit B), with the intent that such payments be used to further the ACO's goals of improving quality and reducing overall cost of care, and for distribution to the physicians providing direct primary care to the ACO patient population.