AGENDA

FINANCE COMMITTEE

MEETING DATE: OCTOBER 16, 2012
TIME: 9:00 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER — BERNARD ROSEN

ADOPTION OF THE SEPTEMBER 11, 2012 MINUTES

SENIOR VICE PRESIDENT'S REPORT — MARLENE ZURACK

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS — FRED COVINO

INFORMATION ITEMS

1. STATEMENT OF REVENUES & EXPENSES AS OF 6/30/2012 & 2011 — JAY WEINMAN

2. MEDICAID ELIGIBILITY PROCESS – BELLEVUE HOSPITAL CENTER — AARON COHEN/DIANA SANTOS

OLD BUSINESS
NEW BUSINESS
ADJOURNMENT — BERNARD ROSEN

MINUTES

MEETING DATE: SEPTEMBER 11, 2012

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on September 11, 2012 in the 5th floor Board Room with Bernard Rosen presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Bernard Rosen
Alan D. Aviles, Esq
Michael A. Stocker, MD
Josephine Bolus, RN
Emily A. Youssouf
Andrea Cohen, (representing Deputy Mayor Linda Gibbs in a voting capacity)

OTHER ATTENDEES

J. DeGeorge, Analyst, Office of the State Comptroller
M. Disowski, Budget Analyst, OMB
M. Dolan, Senior Assistant Director, DC 37
C. Fiorentini, Analyst, NYC Independent Budget Office (IBO)
J. Garellek, Intern, Commission on the Public's Health System
S. Hill, Account Executive, QuadraMed
R. McIntrye, Account Executive, Siemens
J. Wessler, Commission on the Public's Health System

HHC STAFF

V. Bekker, Chief Financial Officer (CFO), Generations+ Northern Manhattan Health Network
D. Cates, Chief of Staff, Board Affairs

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L. Capponi, Chief Medical Informatics Officer, Information Services
A. Cohen, Chief Financial Officer, South Manhattan Health Network
F. Covino, Corporate Budget Director, Corporate Budget
L. Dehart, Assistant Vice President, Corporate Reimbursement Services/Debt Finance
N. Doyle, Senior Assistant Vice President, Human Resources Workforce Development
L. Free, Senior Director, Corporate Managed Care
K. Garramone, Chief Financial Officer, North Bronx Healthcare Network
G. Guilford, Senior Director, Office of the Senior Vice President/Finance/Managed Care
E. Guzman, Chief Financial Officer, Metropolitan Hospital Center
W. Hanus, Controller, MetroPlus, Health Plan
H. Hull, Director of Investigations, Corporate Office of the Inspector General
V. Kim, Senior Director, Corporate Planning Services
C. Jacobs, Senior Vice President, Patient Safety, Accreditation & Regulatory Services
J. John, Chief Financial Officer, Central Brooklyn Family Health Network
L. Johnston, Senior Assistant Vice President, Medical & Professional Affairs
J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations
M. Katz, Senior Assistant Vice President, Corporate Revenue Management
D. Lesane, Associate Director, Kings County Hospital Center
P. Lockhart, Secretary to the Corporation, Office of the Chairman
P. Lok, Director, Debt Finance/Corporate Reimbursement Services
N. Mar, Director, Corporate Finance
A. Marengo, Senior Vice President, Communications/Marketing
H. Mason, Deputy Executive Director, Kings County Hospital Center
R. Mayer, Director, Internal Audits
T. Mammo, Chief of Staff, Office of the President
K. McGrath, Senior Director, Corporate Communications/Marketing
D. Moskos, Director, Facilities Development
F. Ortiz, Senior Associate Director, North Brooklyn Health Network
P. Pandolfini, Chief Financial Officer, Southern Brooklyn/Staten Island Health Network
A. Pistone, Assistant Vice President, Office of Facilities Development
J. Perrine, 1st Deputy IG, Office of the Inspector General
D. Powell, Assistant Director, Marketing, Gouverneur Healthcare Services
B. Robles, Senior Vice President, Chief Information Officer, Information Services
S. Russo, General Counsel, Office of Legal Affairs
W. Saunders, Assistant Vice President, Intergovernmental Relations
D. Santos, Senior Associate Executive Director, Bellevue Hospital Center
B. Stacey, Chief Information Officer, Queens Health Network
J. Wale, Senior Assistant Vice President, Office of Behavioral Health
M. Weinberg, Executive Director, Metropolitan Hospital Center
J. Weinman, Corporate Comptroller, Corporate Comptroller's Office
M. Williams, Assistant Vice President, Affirmative Action/EEO
R. Wilson, Senior Vice President/ Chief Medical Officer, Medical & Professional Affairs
M. Zurack, Senior Vice President, Corporate Finance/Managed Care

Minutes of the September 11, 2012 Finance Committee Meeting

CALL TO ORDER **BERNARD ROSEN**

The meeting of the Finance Committee was called to order at 9:05 a.m. The minutes of the July 10, 2012 Finance Committee meeting were adopted as submitted.

CHAIR'S REPORT **BERNARD ROSEN**

SENIOR VICE PRESIDENT'S REPORT **MARLENE ZURACK**

Ms. Zurack informed the Committee that she had four items to report, a FICA refund; status of cash on hand (COH), a Soarian update and a retirement announcement. Ms. Zurack began with the announcement of Carol Ungar's retirement. Ms. Ungar retired after thirty six years at HHC working in Corporate Revenue Management where she managed all of the collection agency contracts for the Corporation. Ms. Ungar has worked very closely with many of the consumer advocates on resolving some very difficult issues in managing and overseeing those agencies to ensure that HHC patients were treated fairly. Congratulations to Carol on her retirement.

Ms. Zurack stated that HHC is approaching its 3rd phase of the Soarian implementation. The Revenue Management Information System was presented to the Board in 2007. Since that time, two functions, Document Imaging and the Decision Support were implemented. Currently, HHC has reached the core of its implementation which is the scheduling and on September 24, 2012 the first facility that will "go live" with this function will be Coney Island. The implementation of that function will activate the enterprise-wide data base which in essence will establish a way of centralizing appointments scheduling throughout the Corporation that will result in only one master index for all of HHC's patients, which is Phase I of the scheduling function that represents only a fraction of the implementation. Therefore, September 24, 2012 is a very important milestone for HHC in terms of this project. The first set of sites to undergo the implementation includes Bellevue, Gouverneur and Metropolitan and by January 2013 – March 2013 the remaining facilities will be implemented. The next major function that will come several months after the completion of the scheduling phase will be the financial function. A more in-depth report on this Phase will be presented by Ms. Katz at the November 2012 Medical & Professional Affairs (M&PA)/Information Technology Committee in November 2012.

Dr. Stocker asked how long HHC would continue with the dual number system given that one of the major requirements of a centralized appointment system is that there must be a number that would be common to all patients across the system.

Ms. Katz stated that as part of the initial implementation of Soarian there will be a corporate patient identifier for each patient which has been done off-line for more than a year but will now be taken over by Soarian, whereby the structure has been established so that a single number can be used in its

entirety. However, for now each facility's local medical record number will remain in effect. Additionally, in the Soarian master patient index, the individual needs along with the patient identifier, and each site that the patient has been with their local medical record number will be maintained. Eventually HHC will be able to go to a single medical record number but locally the facilities will continue to use the local medical record number.

Dr. Stocker asked if a patient from Coney Island hospital goes to Bellevue Hospital Center would that patient get a corporate patient identifier or both.

Ms. Katz stated that at this stage the patient would get both given that converting to a single number would be a major undertaking but within the Soarian system, HHC will have the capability to go to a single number in the future as determined by HHC.

Ms. Zurack added that it would require a more extensive discussion than just the revenue cycle system and would involve mostly IT given that it relates to the medical record component.

Dr. Stocker asked if the system would be integrated with the new electronic medical record (EMR). Ms. Katz stated that it would be and that discussions with Dr. Louis Capponi, Chief Medical Informatics Officer, on this issue have been extensive in order to ensure that the requirements for the integration are in place in Soarian in anticipation of the EMR.

Dr. Stocker added that some of the facilities have integrated their appointment system locally such as Woodhull Hospital.

Ms. Katz stated that some of the facilities have a centralized call center but there are separate data bases within Siemens. There is only one data base from an appointment scheduling perspective. Although within some networks, that system has been implemented, such as Woodhull and Cumberland; Harlem and Renaissance but from an appointment scheduling, the appointments are being booked into separate data bases.

Dr. Stocker stated that appointments scheduling is very local in some of the clinics that include all of the variations tailored to their requirement needs.

Ms. Zurack stated that the templates are being standardized corporate-wide as part of the installation.

Dr. Stocker asked if there are agreements by the facilities in support of that action. Ms. Zurack stated that the facilities have agreed as part of a value stream (VS) that was undertaken by Ms. Katz as part of Breakthrough to standardize the templates, whereby there were several improvements that took place as part of that process. The clinical staff and a number of others including Dr. Ross Wilson, Senior Vice President, and Chief Medical Officer were involved.

Dr. Stocker asked if any issues are anticipated from the physicians regarding the scheduling system. Ms. Katz stated that agreements were obtained from all of the ambulatory care staff on the appointment types; type of booking activity; standardized activity across the corporation; standardized numbering corporate-wide. Through these efforts, the Corporation was able to obtain consensus. There is some flexibility in the length of the appointment but standard within the template.

Ms. Youssouf asked if the patient would be assigned two numbers.

Ms. Zurack stated that the baseline for understanding this implementation is that currently patients have different medical record numbers at some of the facilities. HHC patients will have a different medical record number for each facility with the exception of those networks that have created a single medical record number. Some patients may have multiple medical record numbers in the same hospital based on the information provided by the patient. There are numerous medical record numbers for HHC's 1.3 million patients which make the goal of going to a single number more difficult. This is only step one of a multiple phase project. Each patient will be given a number and all of the medical record numbers will be linked to that number. In order to go to a single number, all of the data bases would need to be unified on the medical record side, which at this stage HHC is not prepared to do at this time. However, the feedback from the Committee is very helpful in assisting HHC in this implementation process. Currently in order for a patient to make an appointment, the patient must be in that hospital's current system and to make an appointment at another facility it would require logging in and out to that different hospital. This process will be eliminated with this implementation phase. This is a major change for HHC. HHC's IT systems are basically set-up as though HHC is functioning as separate organizations and with this phase of Soarian, HHC would be phasing into one organization with data and to migrate is a major task. The purpose of this update was to keep the Committee informed of the implementation as HHC moves forward. As previously mentioned, there will be a more detailed discussion in November 2012 at the MPA/IT Committee which will be after the September 24, 2012 implementation at Coney Island. Additionally, at that point, HHC will have an early read on the progress of the initial "go-live" implementation.

Mr. Rosen asked if the milestone for HHC is the upcoming implementation at Coney Island and whether by November 2012, all patients will get a new number. Ms. Zurack stated that patients will get a patient identifier number which will be linked to the existing multiple medical record numbers.

Mrs. Bolus asked if the patient would be given a card will both numbers. Ms. Katz stated that each facility has its own system in terms of the issuance of the cards. However, from a corporate perspective, that would be another project that will be addressed in the future. Currently within Soarian the capability from a technology perspective to address that issue exists.

Ms. Zurack added that the issuance of a card was not in the initial work plan and would be expensive to do at this time; however, with the implementation of this phase, HHC will have the capability to do it if and when it is decided.

Ms. Katz added that it would be more realistic to wait until after the implementation of the EMR so that the process is fully implemented, integrated and in-sync with that system. Also it is important to ensure that HHC does not implement things that might require changes in the future that could be costly. There are other things such kiosks, portals, and biometrics that have also been discussed with clinical IT and concluded that having the structure in place is essential in order to allow HHC to do those thing in the future.

Ms. Youssouf asked if it is based on the EMR system or multiples. Ms. Katz stated that the structure that is currently being developed in Soarian is not based on the implementation of any particular EMR system but rather the business needs; how HHC will proceed and how an EMR would work at HHC.

Mr. Rosen asked what will happen after Coney Island hospital goes "live" and a patient is entered into the system. Ms. Katz stated that based on a name or demographic search in Soarian, it would show the facilities that the patient has gone. However, due to Health Insurance Portability and Accountability Act (HIPAA) requirements, if it is not the local site for that patient, the actual medical record number will not be displayed as part of the protective information.

Dr. Stocker asked if within the system there is an edit check to ensure the true identity of a patient based on the information in the data base.

Ms. Katz stated that there are weighted algorithms based on a certain weight if there is a social security number, date of birth, weight, age, gender, and other factors that will determine the identity of the patient.

Ms. Cohen asked if the standardized template included new policies relative to appointment scheduling as part of the process or whether that would be determined after the implementation.

Ms. Katz stated that there have been standard work regarding the appointment links; on the activities types and the definition of those types of activities but not the clinical practices. However, there is flexibility in terms of adjusting the time required by the physician.

Ms. Zurack stated that it is an enabler not the operational decision of the system. Currently the templates are being customized and there are a number of variations; however, with this system that will be eliminated and the way in which the templates are used to actually make appointment decisions is not standardized.

Ms. Youssouf asked if the Committee could get a status report on the outcome of the implementation at Coney Island.

Ms. Zurack stated that an update could be done; however, for Finance the major milestone is the September 24, 2012. Moving to the next item of her report, Ms. Zurack stated that in terms of the cash on hand COH, HHC ended the FY 12 with $460 million or 32 days of COH. As of the end of August 2012, the COH was $302 million or 19 days. Currently the projection for year-end is $140 million and less than 10 days of COH.

Mr. Rosen asked if the year-end reference was June 30, 2013. Ms. Zurack stated that it is the FY 13 ending on June 30, 2013 and that given the severity of this issue, going forward it will require very close monitoring of vendor payments timeframes; and other cash payment issues. In February 2013, a major problem is anticipated that HHC has discussed with the City in terms of rescheduling City payments.

Mr. Rosen asked for clarification of the anticipated problem. Ms. Zurack stated that the projection is that HHC will go negative in February 2013, as included on the first draft of the cash flow. To address this issue, HHC is working on rescheduling City payments to the end of the fiscal year. The last item relates to an IRS refund for FICA payments. The IRS determined in April 2005 that some residents at hospitals should not have paid FICA and that the employers should not have been charged as well. There was an opportunity to recoup retroactive FICA contributions from 1997-2005 which has resulted in an approval from the IRS for HHC to receive in either October or November 2012, $95 million including interest, of which $36 million will go to the residents and $58 million to HHC.

Mr. Rosen asked if the action was brought by HHC. Ms. Zurack stated that HHC joined the action as opposed to filling an action.

Ms. Youssouf asked if the $58 million would offset the projected reduction in the COH. Ms. Zurack stated that it would not since it is already included in the cash flow. The report was concluded.

Mr. Rosen informed the Committee that the reporting by Mr. Covino and Ms. Katz as part of the information items would related to the FY 12 year end status.

KEY INDICATORS REPORT **FRED COVINO**

Mr. Covino reported that as per the Key Indicators as of June 30, 2012, utilization was down by 4.2% in inpatient discharges. A state-wide data search using SPARC to determine how HHC compared to other hospitals in the state and based on that database, HHC is very consistent with the state-wide average; however, HHC was slightly better than some of the other hospitals. Overall, HHC's decline in discharges is fairly consistent across the state. Last year, a review of data compiled by the United Hospital Fund (UHF) was used but it was not available this year. The diagnostic and treatment centers

(D&TC) were down by 5.4% in visits and nursing home days were down by 7.1% due to the transition underway at Coler/Goldwater Specialty Hospital & Nursing Facility. The average length of stay (ALOS) with the exception of Lincoln and Coney Island the remaining hospitals were within 1/3 day of the corporate average. Coney Island was 4/10 greater and Lincoln was ½ day less. The CMI at year end was up by .2% from last year. The CMI was up by 6% last year and 4.5% the year before. Therefore, there has been significant improvement in this area that has been maintained in the last several years. FTEs were down by 508 but 92 FTEs short of the 600 FTE target. In terms of the Networks year-end performance, the North Bronx ended the year with a $50 million surplus which is the 3rd consecutive year with a surplus of more than $30 million. Generations +/Northern Manhattan Network ended the year with a $3 million surplus and has maintained a budget surplus for six consecutive years; South Manhattan ended with a $75 million deficit primarily due to the transitioning at Coler/Goldwater. However, Gouverneur ended the year with a surplus for the 4th consecutive year and Metropolitan improved significantly throughout the year.

Ms. Youssouf asked what the surpluses were attributable to. Mr. Covino stated that it is due in part to two major factors, one being the rollover of prior year surpluses and the Networks ability to maintain a steady flow in its revenues and expenses.

Ms. Zurack stated that it was important to note that those surpluses are only against budget as opposed to cash on the books.

Mr. Rosen added that it is a comparison to the actual to the budget. Ms. Zurack stated that several years ago a decision was made by the Corporation to allow facilities to carryover any surpluses earned in the prior year into the next FY as a result of generating additional revenues and if maintained becomes a cumulative surplus.

Ms. Youssouf asked if there is a time period for those cumulative surpluses. Ms. Zurack stated that there would be if there are major changes, whereby the surpluses are spent as opposed to sustaining the current level or improving it.

Dr. Stocker asked how operating surpluses are distinguished from capital expenditures and whether facilitates are allowed to use those surpluses for capital projects.

Ms. Zurack stated that the two are distinctively separate and facilities have not been allowed to use operating surpluses given the impact it would have on HHC's cash flow. There is money in HHC's capital account that is restricted for capital and there is cash included which is restricted and cannot be used for operating expenses.

Mr. Covino continuing with the reporting, stated that the Central Brooklyn Network ended the year with a $2.6 million deficit which is a major improvement compared to last year. Kings County had a $40 million surplus compared to a $39 million loss last year. Prior to last year Kings County had a

significant number of take backs compared to last year which is a very dramatic change. These changes are primarily due to rate adjustments that can be either upward or downward by the State. The Southern Brooklyn/Staten Island Network had a $27 million surplus for the 4th consecutive year. Queens Network ended with a $5 million surplus compared to last year. The Corporation ended the year with a $9.5 million surplus, receipts were $46 million less than budgeted and disbursements were under budget by $55.5 million. The actual receipts and disbursements compared to the prior year for the year-end, receipts were $42 million worse than the prior year primarily due to a decline in workload and a 2% Medicaid rate reduction. Expenses were $245 million worse than the prior year of which $95 million was due to fringe benefits, of that amount, $90 million was related to pension increases and $78 million was due to an increase in City payments due to timing, and a year and a quarter of malpractice payments compared to three quarters in the prior year. OTPS payments increased by $73 million due to $30 million for environmental contracts and laundry services that will be a part of the OTPS payment stream, and $20 million in fixed assets and $10 million for nurse registry.

Ms. Cohen questioned the reduction in the D&TCs compared to the hospitals. Mr. Covino stated that it was reflective of a trend.

Dr. Stocker asked if there is any SPARC data available for outpatient services. Ms. Zurack stated that the data is not available.

Ms. Cohen asked if the D&TCs were the same as the hospitals outpatient services and the portion of visits for the hospital outpatient to the D&TCs. Ms. Zurack stated that it is approximately 4 to 1 excluding the emergency department.

Mr. Covino stated that page 4 of the report, actual versus the budget as of the FY 12 year-end, receipts were down by $46.5 million due to the continual decline in Medicaid fee-for-service which had a significant decline in workload and 2% rate reduction. Outpatient receipts were up by $46.5 million due to Medicaid managed care whereby there was a $27 million retroactive rate increase from MetroPlus, ER and Ambulatory Surgery rates and a significant increase in the risk pools.

Ms. Youssouf questioned the variance in the appeals & settlements whereby the budget was $59 million compared the actual receipt of $10 million. Mr. Covino stated that it was due to three major appeals that were delayed by the State for payment. The revised APG rate that was budgeted at $30 million; $9 million for psych methodology; an adjustment of $22 million and a chronic rehab rate of $14 million which totaled $72 million for FY 12 but will be received in the current FY 13.

Ms. Youssouf added that if the estimate had been adjusted, the receipts against that budget would have been even. Mr. Covino stated that it would have impacted the bottom-line revenue had that adjustment been made. In conclusion, expenses were $7 million over budget due to overtime

spending of $4.5 million. OTPS expenses were significantly under budget primarily due to under spending in IT.

INFORMATION ITEM **FRED COVINO**
QUARTERLY PS KEY INDICATORS REPORT

Mr. Covino reported that expenses were $7.2 million over budget. However, expenses have decreased due to a reduction in FTEs of 2,800 over the past two years which translates to annual savings of approximately $166 million and $245.8 million including fringes. It is important to understand from a baseline perspective, the impact of the FTE reduction on other expense categories such as overtime, nurse registry and allowances in terms of realigning expenses in order to meet staffing requirements and healthcare needs. As previously stated, of the $7.2 million overage, $4.5 million is attributable to overtime spending and a shortfall of 92 FTEs in the target.

Ms. Youssouf questioned the variations amongst the facilities in that some were significantly over/under budget and asked what it was attributable to.

Mr. Covino stated that some of the facilities have done well in achieving its FTE target and kept spending in overtime and nurse registry to a minimum. Lincoln for instance had increased overtime expense and failed to achieve its FTE target. The two key components of the positive or negative variance are due largely to those two noted factors.

Ms. Youssouf questioned the significant variance at the Coler. Ms. Zurack stated that there are some major capital projects underway at Coler.

Ms. Youssouf asked it that was included in the cost of the capital project or reflected in the budget as an anticipated expense. Ms. Zurack stated that it is not included in the capital project given that it is an expense. There is a new operating procedure (OP) which incorporates the City's Directive 10 that specifically states which expenses are capital eligible and the expenses the hospital operation must incur in order to withstand the disruption in not having the full use of the facility and the impact on service delivery, are not capital eligible.

Ms. Youssouf asked if the cost of moving patients due to a capital project would be a capital expense or a cost on the expense side. Mr. Aviles stated that it would be related to the capital project but would not be capital eligible. Mr. Covino stated that page 3 of the report reflected the reduction in FTEs by facility and page 4 showed the corporate-wide FTE variance by major categories. The bulk of the reduction was in environmental/hotel services, clericals, aides and orderlies.

Ms. Youssouf asked what was included in the managers' category which had the largest increase. Mr. Covino stated that the increase was due to the backfill of vacancies that were vacant in prior years as a result of the facilities effort to achieve its target and backfill after the year ended. There were eight medical record positions at Bellevue; four head nurses at Queens; staff increase for Breakthrough expansion at Generations+ at Harlem; and corporate compliance consolidation. In the tech/specs increase of 53 FTEs, 48 were related to behavioral health associates.

Mr. Rosen asked if the enterprise IT increase of 554 FTEs shown on page 3 was attributable to a consolidation of the staff at the facilities. Ms. Zurack stated that the staff was transferred to the corporate centralized IT cost center.

Mr. Covino stated that on page 5, a comparison of overtime actual to budget showed a $4.5 million increase in spending compared to last year of which $2.5 million was due to Hurricane Irene, the remaining $2 million was related to labs and pharmacy techs, clericals, patient care techs and HCIs.

Ms. Youssouf asked how the overtime variance compared to last two years. Mr. Covino stated that the budget was $2 million less than actual for last year. The budgets are not based on the actuals but rather the base budget with a targeted reduction.

Ms. Zurack added that the variance is fairly consistent with the prior year and the level of the variance is consistent; however, the issue relates either to under-budgeting or controlling expenses.

Mr. Covino stated that page 6, overtime by major service category comparing FY 2012 to FY 2011, nursing was down by 1%; plant maintenance down by 4.3% and all others were up by 8.9%. The trend reflects an increase in overtime spending where there are significant reductions in various key staffing positions such as clericals, special officers, and patient care associates. Page 7 nurse registry showed a $10 million increase which is a significant change from prior years. Nurse registry not only includes registered nurses and LPNs but also nurse aides. There was an increase in one to one coverage for the ICU, CCU and emergency room at Jacobi, NCB and Bellevue; a training program at Lincoln and Bellevue for new staff and nurse shortages. Page 8 showed that there were no major changes in allowances compared to the prior year.

INFORMATION ITEM **MAXINE KATZ**
MEDICAID ELIGIBILITY REPORT – STATUS OF CONVERTING SELF-PAY PATIENTS TO MEDICAID

Ms. Katz stated that the reports were reflective of the FY 12 ending June 30, 2012. Ms. Katz reminded the Committee of the change in the reporting for the current FY 13, whereby the reports will be reported on a quarterly basis in order to coincide with the payor mix reports as agreed to by the

Committee. The Medicaid eligibility report reflected a decrease in the number of Medicaid application submitted but there has been some improvement in the percentage of the applications resulting in eligible decisions by HRA. Last year, the percentage of approvals was at 88% compared to FY 12 at 89%. The overall submissions are less but more of the applications submitted are being approved.

INFORMATION ITEM **MAXINE KATZ**
PAYOR MIX REPORTS – INPATIENT, ADULT & PEDIATRICS

Ms. Katz stated that inpatient discharges payor mix percentage was at 96% corporate-wide for patients insured to the total. There were shifts in the payor mix across the Corporation. The Medicare downward trend is due to a shift to Medicare managed care and a bigger shift from Medicaid to Medicaid managed care and an increase in commercial. As part of the percentage of patients insured to the total there are more patients insured than in prior years.

ADULT PAYOR MIX

Ms. Katz stated that 96% of the visits insured to the total and 92% of the patients were insured to the total which is slightly better than last year at 91% and 95% respectively.

PEDIATRICS PAYOR MIX

Ms. Katz reported that the Pediatrics payor mix has remained steady in both patients and visits insured to the total compared to last year at 98% in FY 12 and 97% in FY 11.

Ms. Cohen asked if HHC Options is an insured and self-pay is not. Ms. Katz replied in the affirmative.

Ms. Zurack added that as a point of clarification, 96% were either insured or enrolled in HHC Options. From the perspective of healthcare policy, those HHC Options patients are uninsured. However, from an HHC perspective, if the patient was interviewed and cooperated with the requirements that patient is categorized as eligible for Options.

Ms. Katz, in concluding the reporting, added that those patients are included in the insured because they are not eligible for public health insurances.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss, the meeting was adjourned at 10:05 a.m.

FY 13 Finance Reports

1. KEY INDICATORS REPORT
2. CASH RECEIPTS & DISBURSEMENTS REPORT

- As of August 2012

NEW YORK CITY HEALTH & HOSPITALS CORPORATION

KEY INDICATORS
FISCAL YEAR 2013 UTILIZATION

Year to Date
August 2012

NETWORKS	UTILIZATION			AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	FY 13	FY 12	VAR %	ACTUAL	EXPECTED	FY 13	FY 12
North Bronx							
Jacobi	3,184	3,326	-4.3%	7.7	7.2	1.2112	1.0723
North Central Bronx	1,299	1,398	-7.1%	4.7	4.8	0.7374	0.6710
Generations +							
Harlem	1,916	1,760	8.9%	5.4	5.6	0.9736	0.9194
Lincoln	3,798	3,942	-3.7%	4.8	5.7	0.9429	0.9401
Belvis DTC	10,256	10,216	0.4%				
Morrisania DTC	14,115	13,607	3.7%				
Renaissance	9,572	11,282	-15.2%				
South Manhattan							
Bellevue	4,119	4,254	-3.2%	6.8	6.5	1.1390	1.1018
Metropolitan	1,941	1,942	-0.1%	4.6	5.2	0.7758	0.7734
Coler	41,991	54,237	-22.6%				
Goldwater	48,299	53,630	-9.9%				
Gouverneur - NF	8,867	12,194	-27.3%				
Gouverneur - DTC	42,945	47,721	-10.0%				
North Central Brooklyn							
Kings County	4,214	3,838	9.8%	5.8	5.7	0.9384	1.0038
Woodhull	2,343	2,421	-3.2%	5.0	5.0	0.8498	0.8045
McKinney	19,255	19,516	-1.3%				
Cumberland DTC	15,936	16,606	-4.0%				
East New York	13,093	13,620	-3.9%				
Southern Brooklyn / S I							
Coney Island	2,948	2,783	5.9%	6.4	6.1	1.0344	1.1196
Seaview	18,371	18,479	-0.6%				
Queens							
Elmhurst	4,235	4,250	-0.4%	5.4	5.3	0.9260	0.9076
Queens	2,148	2,377	-9.6%	5.8	5.5	0.9118	0.8525
Discharges/CMI-- All Acutes	32,145	32,291	-0.5%			0.9648	0.9542
Visits-- All D&TCs	105,917	113,052	-6.3%				
Days-- All SNFs	136,783	158,056	-13.5%				

Notes:

Utilization

Acute: discharges excluding psych and rehab; D&TC; reimburseable visits; SNF; chronic and rehab days

Average Length of Stay

Actual: discharges divided by days; excludes one day stays.

Expected: weighted average of DRG specific corporate average length of stay using APR-DRGs

All Payor CMI

All acute discharges are grouped using the 2012 New York State APR-DRGs

KEY INDICATORS

FISCAL YEAR 2013 BUDGET PERFORMANCE ($s in 000s)

Year to Date
August 2012

NETWORKS	FTE's VS 6/2/12	RECEIPTS actual	RECEIPTS better / (worse)	DISBURSEMENTS actual	DISBURSEMENTS better / (worse)	BUDGET VARIANCE better / (worse)	
North Bronx							
Jacobi	(25.0)	$ 85,927	$ 9,367	$ 90,107	$ 1,223	$ 10,591	6.3%
North Central Bronx	(18.0)	27,890	1,647	28,195	2,262	3,909	6.9%
	(43.0)	$ 113,817	$ 11,014	$ 118,301	$ 3,486	$ 14,500	6.5%
Generations +							
Harlem	(8.5)	$ 50,854	$ (1,551)	$ 55,939	$ (154)	$ (1,705)	-1.6%
Lincoln	31.5	66,824	(4,256)	82,780	(4,052)	(8,308)	-5.5%
Belvis DTC	(1.0)	1,307	(272)	2,461	459	187	4.2%
Morrisania DTC	(2.5)	2,087	(270)	4,175	909	639	8.6%
Renaissance	(1.5)	1,445	83	3,343	133	216	4.5%
	18.0	$ 122,517	$ (6,267)	$ 148,698	$ (2,704)	$ (8,970)	-3.3%
South Manhattan							
Bellevue	(53.0)	$ 90,434	$ (10,889)	$ 119,666	$ (3,627)	$ (14,516)	-6.7%
Metropolitan	(20.0)	42,420	(2,363)	50,813	3,996	1,633	1.6%
Coler	(7.5)	10,241	606	20,736	(4,808)	(4,201)	-16.4%
Goldwater	(19.0)	15,307	(925)	30,407	(8,124)	(9,049)	-23.5%
Gouverneur	(2.5)	10,902	1,453	13,891	1,335	2,787	11.3%
	(102.0)	$ 169,305	$ (12,119)	$ 235,513	$ (11,227)	$ (23,346)	-5.8%
North Central Brooklyn							
Kings County	(15.0)	$ 95,258	$ (6,652)	$ 111,406	$ 695	$ (5,957)	-2.8%
Woodhull	(2.0)	51,084	(5,485)	63,519	(2,453)	(7,938)	-6.7%
McKinney	(2.5)	4,641	(1,105)	7,511	903	(202)	-1.4%
Cumberland DTC	(4.0)	6,242	2,894	5,044	52	2,946	34.9%
East New York	1.0	1,646	(842)	3,589	644	(197)	-2.9%
	(22.5)	$ 158,871	$ (11,191)	$ 191,070	$ (158)	$ (11,348)	-3.1%
Southern Brooklyn/SI							
Coney Island	(13.0)	$ 43,765	$ 615	$ 57,397	$ (586)	$ 29	0.0%
Seaview	(6.0)	7,358	1,592	8,526	(859)	733	5.5%
	(19.0)	$ 51,124	$ 2,206	$ 65,924	$ (1,445)	$ 761	0.7%
Queens							
Elmhurst	(27.0)	$ 84,760	$ 7,104	$ 85,891	$ 6,897	$ 14,001	8.2%
Queens	1.5	44,301	(2,889)	57,488	(2,168)	(5,056)	-4.9%
	(25.5)	$ 129,060	$ 4,216	$ 143,379	$ 4,729	$ 8,945	3.3%
NETWORKS TOTAL	**(194.0)**	**$ 744,693**	**$ (12,140)**	**$ 902,885**	**$ (7,319)**	**$ (19,459)**	**-1.2%**
Central Office	(1.5)	9,928	1,423	48,824	3,194	4,617	7.6%
HHC Health & Home Care	(2.5)	3,235	(1,830)	5,801	855	(975)	-8.3%
Enterprise IT	16.0	0	0	28,676	1,462	1,462	4.9%
GRAND TOTAL	**(182.0)**	**$ 757,857**	**$ (12,547)**	**$ 986,185**	**$ (1,808)**	**$ (14,354)**	**-0.8%**

Notes:

Residents & Grants are included in the reported FTE's.
Reported FTE's are compared to 6/18/11.

New York City Health & Hospitals Corporation
Cash Receipts and Disbursements (CRD)
Fiscal Year 2013 vs Fiscal Year 2012 (in 000's)
TOTAL CORPORATION

	Month of August 2012			Fiscal Year To Date August 2012		
	actual 2013	actual 2012	better / (worse)	actual 2013	actual 2012	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 92,829	$ 92,150	$ 679	$ 164,716	$ 177,329	$ (12,613)
Medicaid Managed Care	58,493	49,590	8,902	115,039	92,121	22,919
Medicare	64,167	65,531	(1,365)	102,694	111,448	(8,754)
Medicare Managed Care	18,958	23,399	(4,440)	39,049	43,771	(4,722)
Other	20,063	19,724	339	40,265	36,254	4,011
Total Inpatient	$ 254,509	$ 250,395	$ 4,115	$ 461,763	$ 460,922	$ 841
Outpatient						
Medicaid Fee for Service	$ 18,413	$ 17,775	$ 637	$ 33,449	$ 32,943	$ 507
Medicaid Managed Care	32,397	24,650	7,747	61,668	49,835	11,833
Medicare	5,806	7,426	(1,620)	10,664	12,972	(2,308)
Medicare Managed Care	7,934	5,791	2,143	14,325	11,633	2,691
Other	10,670	13,167	(2,496)	24,770	24,606	164
Total Outpatient	$ 75,220	$ 68,809	$ 6,411	$ 144,876	$ 131,989	$ 12,887
All Other						
Pools	$ 14,003	$ 6,105	$ 7,899	$ 101,300	$ 101,031	$ 268
DSH / UPL	-	17,750	(17,750)	-	17,750	(17,750)
Grants, Intracity, Tax Levy	34,483	33,840	643	44,894	48,126	(3,232)
Appeals & Settlements	(2,443)	(710)	(1,733)	(4,316)	1,000	(5,316)
Misc / Capital Reimb	5,008	3,735	1,273	9,340	8,408	932
Total All Other	$ 51,051	$ 60,720	$ (9,668)	$ 151,218	$ 176,316	$ (25,098)
Total Cash Receipts	**$ 380,781**	**$ 379,923**	**$ 857**	**$ 757,857**	**$ 769,227**	**$ (11,370)**
Cash Disbursements						
PS	$ 279,664	$ 186,034	$ (93,631)	$ 477,675	$ 377,619	$ (100,056)
Fringe Benefits	53,657	72,684	19,027	127,655	154,780	27,126
OTPS	110,803	100,144	(10,659)	200,778	203,104	2,326
City Payments	13,896	15,903	2,007	13,896	15,903	2,007
Affiliation	74,977	77,499	2,523	149,972	148,013	(1,959)
HHC Bonds Debt	7,949	7,955	6	16,209	16,164	(45)
Total Cash Disbursements	**$ 540,945**	**$ 460,219**	**$ (80,727)**	**$ 986,185**	**$ 915,584**	**$ (70,601)**
Receipts over/(under) Disbursements	**$ (160,165)**	**$ (80,296)**	**$ (79,869)**	**$ (228,329)**	**$ (146,358)**	**$ (81,971)**

New York City Health & Hospitals Corporation
Actual vs. Budget Report
Fiscal Year 2013 (in 000's)
TOTAL CORPORATION

	Month of August 2012			Fiscal Year To Date August 2012		
	actual 2013	budget 2013	better / (worse)	actual 2013	budget 2013	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 92,829	$ 100,813	$ (7,984)	$ 164,716	$ 179,570	$ (14,854)
Medicaid Managed Care	58,493	57,205	1,288	115,039	107,023	8,016
Medicare	64,167	57,939	6,227	102,694	99,627	3,067
Medicare Managed Care	18,958	18,621	337	39,049	40,962	(1,913)
Other	20,063	22,575	(2,513)	40,265	41,452	(1,188)
Total Inpatient	$ 254,509	$ 257,153	$ (2,644)	$ 461,763	$ 468,634	$ (6,871)
Outpatient						
Medicaid Fee for Service	$ 18,413	$ 19,347	$ (934)	$ 33,449	$ 34,498	$ (1,049)
Medicaid Managed Care	32,397	34,146	(1,749)	61,668	65,322	(3,654)
Medicare	5,806	7,410	(1,604)	10,664	12,886	(2,222)
Medicare Managed Care	7,934	6,368	1,566	14,325	12,182	2,143
Other	10,670	14,829	(4,159)	24,770	27,393	(2,623)
Total Outpatient	$ 75,220	$ 82,099	$ (6,879)	$ 144,876	$ 152,280	$ (7,404)
All Other						
Pools	$ 14,003	$ 14,124	$ (121)	$ 101,300	$ 101,440	$ (140)
DSH / UPL	-	-	0	-	-	0
Grants, Intracity, Tax Levy	34,483	30,950	3,532	44,894	37,620	7,275
Appeals & Settlements	(2,443)	-	(2,443)	(4,316)	-	(4,316)
Misc / Capital Reimb	5,008	5,794	(786)	9,340	10,429	(1,090)
Total All Other	$ 51,051	$ 50,869	$ 183	$ 151,218	$ 149,489	$ 1,729
Total Cash Receipts	**$ 380,781**	**$ 390,121**	**$ (9,340)**	**$ 757,857**	**$ 770,403**	**$ (12,547)**
Cash Disbursements						
PS	$ 279,664	$ 281,018	$ 1,354	$ 477,675	$ 480,703	$ 3,028
Fringe Benefits	53,657	54,681	1,025	127,655	129,559	1,905
OTPS	110,803	105,016	(5,786)	200,778	195,204	(5,574)
City Payments	13,896	12,839	(1,057)	13,896	12,839	(1,057)
Affiliation	74,977	74,996	20	149,972	149,992	20
HHC Bonds Debt	7,949	8,039	90	16,209	16,079	(130)
Total Cash Disbursements	**$ 540,945**	**$ 536,591**	**$ (4,355)**	**$ 986,185**	**$ 984,378**	**$ (1,808)**
Receipts over/(under) Disbursements	**$ (160,165)**	**$ (146,470)**	**$ (13,695)**	**$ (228,329)**	**$ (213,975)**	**$ (14,354)**

Annual Deficit in budgeted receipts vs disbursements is funded through reserves

NEW YORK CITY HEALTH & HOSPITALS CORPORATION

FY 2013 INITIAL BUDGET ALLOCATION BY NETWORK/FACILITY

FY2013 Initial Budget
(in $000's)

	Corporate Totals	Jacobi	North Central Bronx	Harlem	Lincoln	Morrisania DTC	Renaissance	Belvis DTC
Cash Receipts								
Inpatient								
Medicaid Fee for Service	$ 1,171,478	$ 91,467	$ 24,101	$ 64,821	$ 81,722	$ -	$ -	$ -
Medicaid Managed Care	608,651	79,199	24,508	40,077	75,356	-	-	-
Medicare	543,384	73,388	14,986	30,785	44,790	-	-	-
Medicare Managed Care	263,832	25,680	6,283	15,673	37,239	-	-	-
Other	235,643	33,040	6,030	12,884	18,743	-	-	-
Total Inpatient	$ 2,822,986	$ 302,774	$ 75,909	$ 164,240	$ 257,851	$ -	$ -	$ -
Outpatient								
Medicaid Fee for Service	$ 222,383	$ 11,909	$ 6,271	$ 12,445	$ 15,803	$ 948	$ 878	$ 649
Medicaid Managed Care	467,589	49,869	24,046	15,838	41,318	12,742	6,058	9,340
Medicare	70,001	11,755	2,304	2,678	5,855	44	55	38
Medicare Managed Care	97,935	5,122	1,736	5,959	11,691	1,622	1,630	674
Other	165,195	15,979	5,461	9,646	12,291	1,643	1,569	1,091
Total Outpatient	$ 1,023,104	$ 94,634	$ 39,818	$ 46,566	$ 86,958	$ 17,000	$ 10,190	$ 11,791
All Other								
Pools	$ 440,308	$ 29,837	$ 28,225	$ 56,647	$ 46,194	$ 1,386	$ 1,245	$ 816
DSH / UPL	1,287,000	75,359	26,566	45,579	69,652	1,426	1,120	910
Grants, Intracity, Tax Levy	275,997	13,498	6,288	14,203	14,689	4,205	3,692	1,290
Appeals & Settlements	35,637	5,860	3,414	(4,115)	5,324	-	-	-
Misc / Capital Reimb	60,259	10,071	260	2,818	2,285	203	283	73
Total All Other	$ 2,099,201	$ 134,625	$ 64,752	$ 115,131	$ 138,144	$ 7,220	$ 6,340	$ 3,089
Total Cash Receipts	**$ 5,945,291**	**$ 532,033**	**$ 180,479**	**$ 325,938**	**$ 482,953**	**$ 24,220**	**$ 16,529**	**$ 14,881**
Cash Disbursements								
PS	$ 2,421,201	$ 221,272	$ 71,974	$ 134,055	$ 183,422	$ 12,398	$ 8,981	$ 7,833
Fringes	1,241,260	111,846	37,366	68,694	91,800	6,475	4,915	3,922
OTPS	1,204,643	105,995	41,752	58,615	112,672	9,067	4,400	4,587
City Payments	375,790	44,088	11,097	26,020	37,640	368	207	107
Affiliation	921,749	96,597	35,949	64,494	92,244	590	3,458	706
HHC Bonds Debt	$ 96,474	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Cash Disbursements	**$ 6,261,117**	**$ 579,798**	**$ 198,137**	**$ 351,878**	**$ 517,777**	**$ 28,897**	**$ 21,961**	**$ 17,155**
Receipts over/ (under) Disb		**$ (47,766)**	**$ (17,658)**	**$ (25,940)**	**$ (34,824)**	**$ (4,677)**	**$ (5,431)**	**$ (2,274)**

Annual Deficit in budgeted receipts vs disbursements is funded through reserves

FY2013 Initial Budget
(in $000's)

	Bellevue	Metropolitan	Coler	Goldwater	Gouverneur
Cash Receipts					
Inpatient					
Medicaid Fee for Service	$ 185,661	$ 64,206	$ 55,428	$ 93,272	$ 12,287
Medicaid Managed Care	82,819	48,643	883	716	814
Medicare	73,328	22,665	1,397	4,417	3,014
Medicare Managed Care	38,396	20,632	213	178	2,634
Other	42,944	7,516	1,842	1,413	2,052
Total Inpatient	$ 423,148	$ 163,663	$ 59,764	$ 99,997	$ 20,801
Outpatient					
Medicaid Fee for Service	$ 27,522	$ 14,779	$ -	$ -	$ 5,792
Medicaid Managed Care	32,762	30,100	-	-	16,390
Medicare	8,016	3,323	-	-	1,578
Medicare Managed Care	11,524	4,753	-	-	8,137
Other	16,081	5,740	-	-	3,680
Total Outpatient	$ 95,904	$ 58,695	$ -	$ -	$ 35,576
All Other					
Pools	$ 35,431	$ 28,469	$ 1,062	$ 1,219	$ 3,762
DSH / UPL	93,335	41,583	19,355	18,491	9,174
Grants, Intracity, Tax Levy	64,643	6,015	3,804	2,010	7,167
Appeals & Settlements	(22,925)	5,645	(809)	7,152	1,280
Misc / Capital Reimb	15,599	5,434	385	648	1,385
Total All Other	$ 186,084	$ 87,145	$ 23,797	$ 29,520	$ 22,768
Total Cash Receipts	**$ 705,135**	**$ 309,503**	**$ 83,561**	**$ 129,517**	**$ 79,145**
Cash Disbursements					
PS	$ 284,364	$ 129,615	$ 56,154	$ 73,270	$ 45,487
Fringes	139,384	67,167	36,145	42,518	24,053
OTPS	134,592	58,261	669	6,494	10,500
City Payments	33,261	12,272	1,825	2,840	7,032
Affiliation	141,034	52,332	9,925	18,595	8,822
HHC Bonds Debt	$ -	$ -	$ -	$ -	$ -
Total Cash Disbursements	**$ 732,635**	**$ 319,646**	**$ 104,717**	**$ 143,717**	**$ 95,894**
Receipts over/ (under) Disb	**$ (27,500)**	**$ (10,143)**	**$ (21,157)**	**$ (14,200)**	**$ (16,749)**

Annual Deficit in budgeted receipts vs disbursements is funded through reserves

FY2013 Initial Budget
(in $000's)

	Woodhull	Cumberland DTC	Kings County	McKinney	East New York	Coney Island	Seaview
Cash Receipts							
Inpatient							
Medicaid Fee for Service	$ 77,755	$ -	$ 159,127	$ 21,956	$ -	$ 51,517	$ 24,154
Medicaid Managed Care	40,940	-	77,736	1,309	-	34,901	60
Medicare	35,202	-	59,023	4,638	-	84,974	2,287
Medicare Managed Care	20,439	-	33,760	1,123	-	22,600	-
Other	10,940	-	33,341	3,358	-	15,459	6,076
Total Inpatient	$ 185,277	$ -	$ 362,987	$ 32,384	$ -	$ 209,450	$ 32,576
Outpatient							
Medicaid Fee for Service	$ 19,271	$ 3,474	$ 24,122	$ 3,913	$ 2,057	$ 8,657	$ 2,602
Medicaid Managed Care	41,087	9,417	47,210	-	10,017	23,074	-
Medicare	4,288	700	8,753	(535)	65	5,678	-
Medicare Managed Care	10,397	1,244	10,294	-	2,443	3,781	-
Other	16,452	5,294	22,331	89	1,668	10,810	700
Total Outpatient	$ 91,496	$ 20,128	$ 112,711	$ 3,467	$ 16,250	$ 52,001	$ 3,302
All Other							
Pools	$ 36,753	$ 1,605	$ 79,881	$ -	$ 1,020	$ 190	$ -
DSH / UPL	59,707	1,442	102,699	8,224	1,204	48,503	8,655
Grants, Intracity, Tax Levy	13,738	5,484	23,291	2,489	4,874	7,536	155
Appeals & Settlements	242	-	(6,826)	5,105	0	2,509	2,321
Misc / Capital Reimb	1,921	0	4,294	147	91	2,413	286
Total All Other	$ 112,361	$ 8,531	$ 203,339	$ 15,965	$ 7,188	$ 61,151	$ 11,416
Total Cash Receipts	**$ 389,134**	**$ 28,660**	**$ 679,036**	**$ 51,815**	**$ 23,438**	**$ 322,602**	**$ 47,295**
Cash Disbursements							
PS	$ 150,612	$ 13,839	$ 356,829	$ 20,714	$ 13,343	$ 152,611	$ 26,346
Fringes	80,406	8,264	165,045	12,609	6,551	81,260	15,778
OTPS	52,845	3,714	122,842	18,870	6,640	53,252	7,438
City Payments	18,601	1,961	71,116	701	384	27,153	695
Affiliation	98,641	5,434	25,701	-	-	57,983	210
HHC Bonds Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Cash Disbursements	**$ 401,106**	**$ 33,212**	**$ 741,533**	**$ 52,894**	**$ 26,917**	**$ 372,258**	**$ 50,467**
Receipts over/ (under) Disb	**$ (11,972)**	**$ (4,552)**	**$ (62,497)**	**$ (1,079)**	**$ (3,479)**	**$ (49,656)**	**$ (3,172)**

Annual Deficit in budgeted receipts vs disbursements is funded through reserves

FY2013 Initial Budget
(in $000's)

	Elmhurst	Queens	Central Office & Reserves	Enterprise IT	HHC Health & Home Care
Cash Receipts					
Inpatient					
Medicaid Fee for Service	$ 101,579	$ 62,424	$ -	$ -	$ -
Medicaid Managed Care	68,096	32,595	-	-	-
Medicare	56,928	31,563	-	-	-
Medicare Managed Care	24,734	14,247	-	-	-
Other	28,804	11,197	-	-	-
Total Inpatient	$ 280,141	$ 152,027	$ -	$ -	$ -
Outpatient					
Medicaid Fee for Service	$ 21,092	$ 14,486	$ -	$ -	$ 25,715
Medicaid Managed Care	61,497	36,824	-	-	-
Medicare	6,418	6,142	-	-	2,845
Medicare Managed Care	8,912	8,016	-	-	-
Other	16,546	14,846	-	-	3,280
Total Outpatient	$ 114,464	$ 80,314	$ -	$ -	$ 31,839
All Other					
Pools	$ 50,549	$ 36,016	$ -	$ -	$ -
DSH / UPL	72,676	51,341	530,000	-	-
Grants, Intracity, Tax Levy	28,189	9,941	38,596	-	202
Appeals & Settlements	19,829	4,531	-	-	7,100
Misc / Capital Reimb	5,567	2,090	4,000	-	6
Total All Other	$ 176,810	$ 103,919	$ 572,596	$ -	$ 7,308
Total Cash Receipts	**$ 571,414**	**$ 336,260**	**$ 572,596**	**$ -**	**$ 39,147**
Cash Disbursements					
PS	$ 207,921	$ 125,554	$ 56,484	$ 54,446	$ 13,679
Fringes	110,882	66,876	26,867	26,062	6,377
OTPS	123,126	53,750	86,943	107,356	20,264
City Payments	32,186	40,816	4,342	396	683
Affiliation	122,456	86,578	-	-	-
HHC Bonds Debt	$ -	$ -	$ 96,474	$ -	$ -
Total Cash Disbursements	**$ 596,571**	**$ 373,575**	**$ 271,110**	**$ 188,260**	**$ 41,002**
Receipts over/ (under) Disb	**$ (25,156)**	**$ (37,315)**	**$ 301,486**	**$ (188,260)**	**$ (1,855)**

Annual Deficit in budgeted receipts vs disbursements is funded through reserves

INFORMATION ITEM

STATEMENT OF REVENUES & EXPENSES FOR THE PERIOD ENDED 6/30/2011 AND 2012

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of the City of New York)

Statement of Revenue and Expenses

Periods ended June 30, 2012 and 2011

(in thousands)

	HHC		MetroPlus		Inter-Company Elimination Entries		Totals		
	2012	2011	2012	2011	2012	2011	2012	2011	Variance
Operating revenues:									
Net patient service revenue	$ 5,615,776	6,082,278	-	-	(705,976) (1)	(766,918) (1)	4,909,800	5,315,360	(405,560)
Appropriations from (remittances to) the City, net	(9,140)	27,593	-	-	-	-	(9,140)	27,593	(36,733)
Premium revenue	-	(186,846)	1,907,877	1,479,892	(15,881) (2)	(13,656) (2)	1,891,996	1,279,390	612,606
Grants revenue	249,252	212,984	(25)	242	-	-	249,227	213,226	36,001
Other revenue	71,239	47,515	32	4	-	-	71,271	47,519	23,752
Total operating revenues	5,927,127	6,183,524	1,907,884	1,480,138	(721,857)	(780,574)	7,113,154	6,883,088	230,066
Operating expenses:									
Personal services	2,387,461	2,536,720	47,920	46,358	-	-	2,435,381	2,583,078	(147,697)
Other than personal services	1,410,017	1,393,476	1,750,837	1,337,491	(705,976) (1)	(766,918) (1)	2,454,878	1,964,049	490,829
Fringe benefits and employer payroll taxes	1,115,256	1,040,293	22,842	17,656	(15,881) (2)	(13,656) (2)	1,122,217	1,044,293	77,924
Postemployment benefits, other than pension	299,850	611,561	3,315	9,040	-	-	303,165	620,601	(317,436)
Affiliation contracted services	884,436	857,467	-	-	-	-	884,436	857,467	26,969
Depreciation	259,045	254,458	1,862	1,676	-	-	260,907	256,134	4,773
Total operating expenses	6,356,065	6,693,975	1,826,776	1,412,221	(721,857)	(780,574)	7,460,984	7,325,622	135,362
Operating income (loss)	(428,938)	(510,451)	81,108	67,917	-	-	(347,830)	(442,534)	94,704
Nonoperating revenues (expenses):									
Investment income	10,502	12,420	1,476	1,649	-	-	11,978	14,069	(2,091)
Interest expense	(98,678)	(92,868)	-	-	-	-	(98,678)	(92,868)	(5,810)
Noncapital contributions	592	557	-	-	-	-	592	557	35
Total nonoperating revenues (expenses)	(87,584)	(79,891)	1,476	1,649	-	-	(86,108)	(78,242)	(7,866)
Income (Loss)	$ (516,522)	(590,342)	82,584	69,566	-	-	(433,938)	(520,776)	86,838

(1) Represents payments by Metroplus to HHC for medical services. Revenue and expenses are eliminated for consolidation purposes.

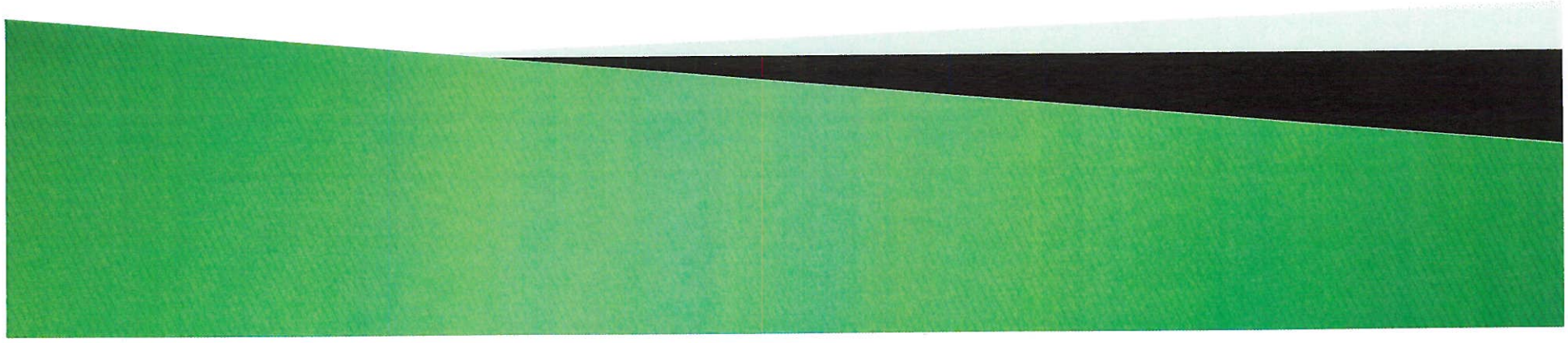
(2) Represents health benefits paid to Metroplus for HHC employees. Revenue and expenses are eliminated for consolidation purposes.

BELLEVUE HOSPITAL CENTER

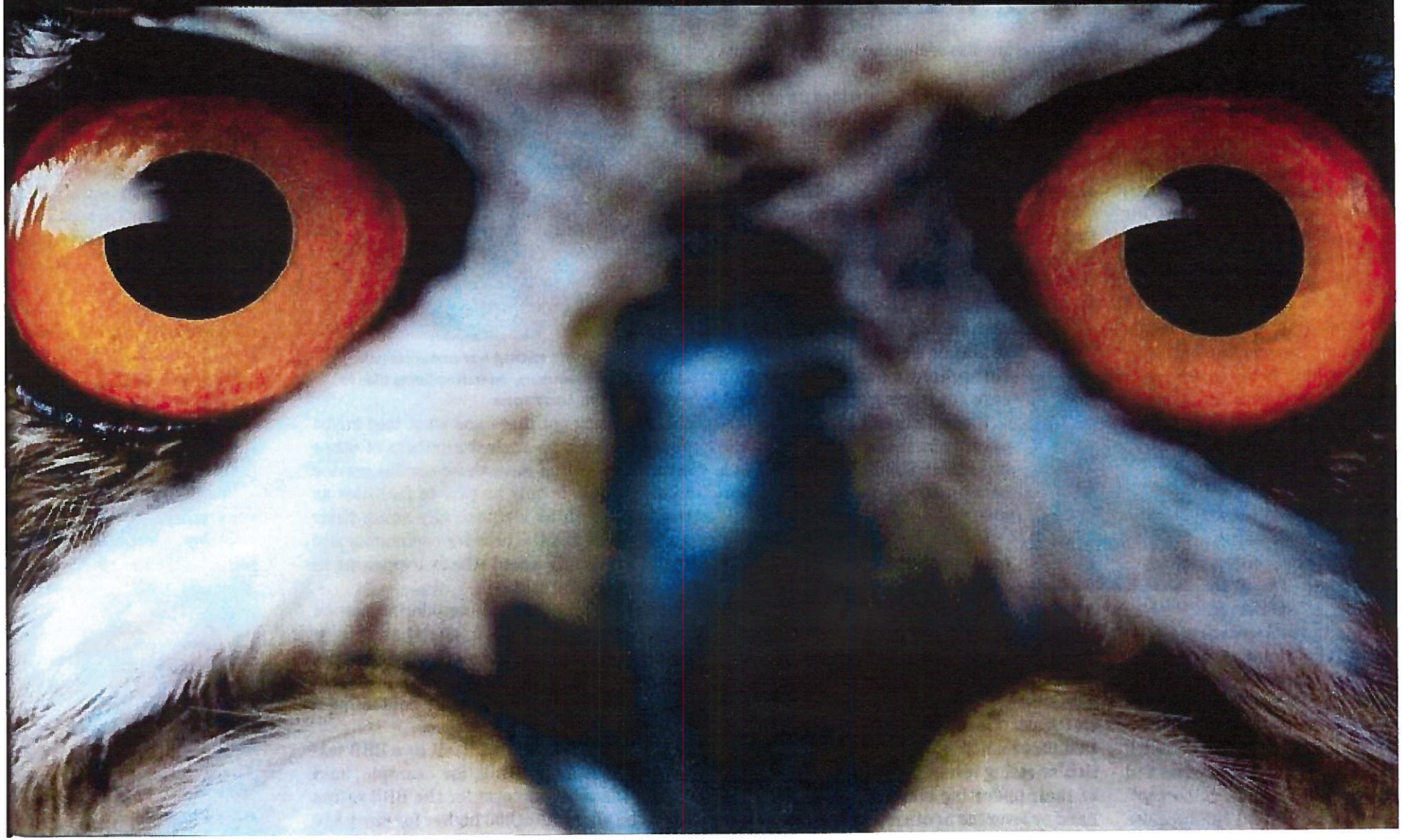
MEDICAID ELIGIBILITY PROCESS

BELLEVUE HOSPITAL CENTER

MEDICAID APPLICATION PROCESS



LOOKING FOR REVENUE?



Reason for Action

What: Follow-up for documentation collection isn't timely and HCIs are unable complete the MA application
When: From FY'10 to FY '11
Who: Inpatient Acute Care Hospitals
Where: Bellevue Hospital Center (this RIE)

Aim: Improve Quality, Quantity and reduce submission time frame of Medicaid applications productivity

Scope: Medicaid Investigation Follow-up

Trigger: HCI receives a case for Medicaid investigation follow-up

Done: Medicaid application is submitted

HHC Value Stream Metrics - FY '11		
Q/S	Eligible Decision	88.8%
H/D	Apps/FTE	TBD
F	IP FFS MA Revenue	$327 Million
D/T	Avg. Time to Submit	81 Days
G/C	Applications Submitted	35,231
G/C	Final Self-Pay	7.12%

Initial State

- Informal follow-up instructions exists our facilities - no standard timeframes for various activities, e.g. phone call, letters
- Cases are handed-off due to patient lack of cooperation - ED to Investigator to A/R/Self-pay Unit, to Collections
- Multiple reviews throughout the investigative process
- Outside resources not fully utilized - e.g. UIB, Shelter system, Worker Connect, etc.
- All staff do not have access to all systems - e.g. eMev, ePaces, MEF, MARC, etc.
- Staff not trained on most recent MA regulations/requirements resulting in delays in application processing
- Do not allow for emailing or faxing of documentation by patients to HCI
- Do not have extended hours of operations for patients/family to return documentation

SIPOC

Suppliers:
patients & families
providers
employers
systems
HHC facilities
HCIs/staff
HRA/other agencies

Inputs:
patient demographics
time
documents
MA applications
relationships with patients/families

Process:
1. Case rec'd by Sr. HCI
2. Case assigned to HCI
3. HCI's conduct system checks, interview patients, collect documents
4. Follow-up on uncollected documents
5. Complete & submit MA application

Outputs:
MA coverage
revenue
access to HHC
MA applications
decisions

Customers:
patient & families
Providers
HHC Facilities
HCIs/staff
HRA/other agencies

RIE Metrics - FY11 (Avg./monthly)

Q/S	# applications submitted	457
H/D	# staff trained in SW for Self-Pay Follow-up Investigations	0
F	# cases sent to collection agencies # self-pay cases	325 473
D/T	• # staff with access to all systems • # accounts in investigation backlog • time between admission and application submission	TBD 600+ unknown
G/C	# eligible decisions # code 2s and 4s	385 72

Target State

- Develop expertise in HHC on use of resources: e.g.: Worker connect, e-mails, e-paces, etc.
- Access all sub-system from one point of entry.
- To train staff utilize all systems available
- Get timely info from outside agencies
- Allow for texting or e-mailing of documentation by patients to investigation
- Extend available hours to bring in documents
- Need address verification technology
- Improve the mail return timeliness/accuracy
- Implement & Assess use of field HCIs to collect necessary documentation

RIE Metrics (Feb 2012)		Baseline	Target
Q/S	# applications submitted	457	+50%
H/D	# staff trained in SW for Medicaid applications follow-up investigations	0	100%
F	# cases sent to collection agencies # self-pay cases	325 473	-50% -50%
D/T	• # staff with access to all systems •# accounts in investigation backlog • time between admission and application submission (FY12 avg)	TBD 600+ unknown	100% -50% -5 days
G/C	# eligible decisions # code 2s and 4s	385 72	+192 -50%

GAPS

- Not enough communication between Admitting and Patient Accounts
  - PA retrieve the new cases twice daily with the first distribution to Investigations not happening until 10am – issues that caused delay were not communicated
- No dedicated Emergency Room HCI
  - the Managed Care unit would see ED patients when possible but this was not their only nor primary function
- Self Pay Process not completely in line with corporate initiative
  - We were not dropping the bills for all self pay accounts 15 days from discharge
  - The HCI's now retain their accounts
- Check, check and double check
  - Multiple reviews throughout the investigative process due to lack of Standard Work for Senior HCI's and HCI's– causing multiple handoffs and system checks
- Staff system access was limited to a need to know basis instead of a more general access
  - System requirements vary by unit so utilizing staff in more than one unit was a challenge because access to the various systems is not always immediate

Bellevue Self Pay Demographics

Very broad catchment area

- 40% from Manhattan
- 60% from other areas- breakdown by outer boroughs, out of state, from other countries, and transfers from other HHC facilities-extremely challenging to obtain documentation from patients who don't reside in Manhattan.

On average 66% of our self pay population is male- single males who

- are not in a federal category and **Medicaid income levels are extremely low** for this category making it very difficult to obtain eligibility
- Transient (homeless or psych) again **very difficult to obtain documentation and eligibility**

Completion Plan

What	Who	When
Review and finalize all Standard Work (for Bellevue)	BHC Steering Committee	April 2012
Review and finalize all Standard Work (for Enterprise-wide spread)	Steering Committee	April 2012
Communicate all standard work to staff	PAPA	April 2012
Develop a Production Control Board (PCB) to track post-RIE results	N. Cassandra Simmons	October 2012
Analyze staff and systems access roster, and expand system access to staff	Michael McLeggan	Still in process
Develop an assessment tool to measure staff's knowledge of MA guidelines	Toni Morton	Not completed
Implement the visual management tool across the department	Toni Morton	March 31, 2012

Items not Completed

- Access for all staff to the Medicare verification system, Omnipro, has been a challenge and is still a work in progress

- A specific tool to assess staff's Medicaid knowledge is still being developed however, we are using the code 2's and 4's as our way to determine staff's knowledge

Confirmed State

Metric		Base (2/12)	Final RIE	30 Days	60 Days	90 Days	Target
Q/S	# applications submitted	457	476	445	518	465	+50%
H/D	# staff trained in SW for MA Investigations Follow-up	24	0	24			100%
F	# cases sent to collection agencies # self-pay cases	325 473	269	323	275	254	-50% -50%
D/T	• # staff with access to all systems •# accounts in investigation backlog • time between admission and application submission (FY12 avg.)	24 600+ Unknown	10 675	607	634	15 622 130	100% -50% -5 days
G/C	# eligible decisions # code 2s and 4s	385 72	389 87	324	437 81	357 108	+192 -50%

IMPROVEMENTS

- Standard work developed and implemented for each job function
- Distribution occurs earlier in the morning and more frequently throughout the day
- Assigned dedicated HCI's to the emergency department and changed staff hours to correspond with peak activity time
- Ongoing training

NEXT STEPS

- 100% Omnipro access
- Develop a tool to assess staffs Medicaid knowledge
- In-service training in the form of 1 on 1, actual case studies, mentoring and weekly staffing huddles focused on issues directly related to the processing of the applications
- Continued dialogue with Medicaid onsite staff to address uneven application of eligibility standards
- Obtain physician signature and documentation of the 4471 and 486T sooner in the process