AGENDA

FINANCE COMMITTEE

MEETING DATE: JANUARY 14, 2014
TIME: 9:00 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER	BERNARD ROSEN
ADOPTION OF THE DECEMBER 10, 2013 MINUTES	
SENIOR VICE PRESIDENT'S REPORT	MARLENE ZURACK
KEY INDICATORS & CASH RECEIPTS/DISBURSEMENTS REPORTS	FRED COVINO KRISTA OLSON
OLD BUSINESS NEW BUSINESS ADJOURNMENT	BERNARD ROSEN

MINUTES

MEETING DATE: DECEMBER 10, 2013

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on December 10, 2013 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

M. Dolan, Senior Assistant Director, DC 37
S. Donovan, Partner, Hawkins Delafield & Wood LLP
C. Fiorentini, Analyst, NYC Independent Budget Office (IBO)
M. Meagher, Unit Head, OMB
K. Raffaele, Analyst, Office of Management & Budget (OMB)
L. Schomp, Analyst, OMB
E. Schneider, HHC Area Director, NYSNA

HHC STAFF

P. Albertson, Senior Assistant Vice President, Corporate Operations/Supply Chain
B. Ancona, Chief Financial Officer, (CFO), Gouverneur Healthcare Services
V. Bekker, CFO, Corporate Finance
M. Brito, CFO, Coler/Goldwater Specialty Hospital & Nursing Facility
L. Brown, Senior Vice President, Corporate Planning, Community Health & Intergovernmental Rel
D. Buzzeo, Associate Executive Director, Lincoln Medical & Mental Health Center
T. Carlisle, Associate Executive Director, Corporate Planning
D. Cates, Chief of Staff, Board Affairs

Minutes of the December 10, 2013 Finance Committee Meeting

A. Cohen, CFO, South Manhattan Health Network
D. Collington, Assistant Director, Coney Island Hospital
F. Covino, Corporate Budget Director, Corporate Budget
L. Dehart, Assistant Vice President, Corporate Reimbursement Services/Debt Financing
K. Garramone, Chief Financial Officer, North Bronx Healthcare Network
G. Guilford, Assistant Vice President, Office of the Senior Vice President/Finance/Managed Care
L. Guttman, Assistant Vice President, Corporate Intergovernmental Relations
J. John, Chief Financial Officer, Central Brooklyn Family Health Network
M. Katz, Senior Assistant Vice President, Corporate Revenue Management
P. Lockhart, Secretary to the Corporation, Office of the Chairman
T. Mammo, Chief of Staff, Office of the President
N. Mar, Director, Corporate Reimbursement Services/Debt Financing
A. Moran, CFO, Elmhurst Hospital Center
D. Moskos, Director, Facilities Development
K. Olson, Assistant Vice President, Corporate Budget
P. Pandolfini, Chief Financial Officer, Southern Brooklyn/Staten Island Health Network
K. Park, Associate Executive Director, Queens Health Network
B. Robles, Senior Vice President/CCIO, Information Services
S. Russo, Senior Vice President, General Counsel, Office of Legal Affairs
B. Stacey, CFO, Queens HealthCare Network
L. Tullouch, CFO, Acting, Harlem Hospital Center
L. Villalon, Deputy CFO, Coler/Goldwater Specialty Hospital & Nursing Facility
R. Walker, CFO, North Brooklyn Health Network
J. Weinman, Corporate Comptroller, Corporate Comptroller's Office
M. Williams, Assistant Vice President, EEO/Affirmative Action
R. Wilson, Senior Vice President/ Chief Medical Officer, Medical & Professional Affairs
J. Wool, Executive Director, Queens Hospital Center
M. Zurack, Senior Vice President, Corporate Finance/Managed Care

Minutes of the December 10, 2013 Finance Committee Meeting

CALL TO ORDER **BERNARD ROSEN**

CHAIR'S REPORT **BERNARD ROSEN**

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

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

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

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

Mr. Rosen asked for clarification of the year-end referenced by Ms. Zurack whether it related to fiscal or calendar year and how the projected cash balance for FY 14 compares to FY 13. Ms. Zurack stated that it is approximately $75 million higher.

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

Mr. Bekker stated that the work began on this project two months ago as part of Ms. Zurack's efforts to formulate a team to address the requirements of the Exchanges as part of the Affordable Care Act (ACA). There are a number of issues involved in the Medicaid enrollment process and how that will affect HHC's revenue is yet to be determined. HHC staff must be trained and certified as application

counselor (CAC). There are seventeen plans in the State of NY. The CAC is similar to the Navigator except that the Navigators are funded through a federal grant. There are the Modified Adjusted Gross Income (MAGI) and the non-MAGI. The coverage for MAGI is up to 65 years of age and Child Health Plus (CHP) up to 400% of the federal poverty level (FPL). There is no asset test; however, the cap is $11,940.

Ms. Zurack added that the income requirement follows the IRS guidelines. Social security is not exempt if it is less than $25,000. Ms. Youssouf asked whether social security counts. Mr. Bekker stated that over $25,000.

Mr. Rosen asked what the current FPL is. Mr. Bekker stated that it is $11,940 for a single person.

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

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

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

Ms. Cohen asked the difference between that process and the current one in terms of what the applicants are required to do and whether it is more complicated.

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

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

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

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

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

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

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

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

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

Mr. Bekker stated that MetroPlus must be identified as a Qualified Health Plan (QHP).

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

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

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

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

Mr. Wool stated that the overall implementation of the ACA and the health Exchanges in NYS could be very positive. The State is projecting that 1.1 million of the 2.7 million uninsured will get health insurance through the health exchanges. As Mr. Bekker indicated there are some disadvantages and risks. The Breakthrough event included representation from all of the acute hospitals in HHC, subject matter experts from MetroPlus, NYC OMB and HRA, various central office key divisions, information technology, managed care, revenue management and human resources. The initial event was focused

on the inpatient application process. However, there is an event underway focusing on the outpatient application process. In the current state, there are approximately 190 employees who are hospital care investigators (HCI) in the acute care hospitals assisting patient in enrolling in Medicaid which generally covers the patient current inpatient admission.

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

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

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

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

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

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

complicated in terms of having to assist individuals in the new process of providing income that is consistent with that individual last tax return filing.

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

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

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

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

in the process of modifying the job description for the HCI, a communication plan and a monitoring plan for the staff.

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

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

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

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

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

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

Ms. Zurack stated that HHC's intermediary in getting the staff trained has been Greater New York Hospital Association (GNYHA) who has been extremely helpful most notably, Stuart Presser of GNYHA.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Aviles stated that theoretically HHC can make the necessary payment on behalf of the patient in order to get the retroactive coverage so that the cost of the inpatient stay, $20,000 will be paid based on a $115 premium for the patient.

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

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

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

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

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

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

Ms. Zurack stated that in preparation for HHC's incentive meeting, information was shared with HHC's senior leadership that addresses what a patient pays on Options versus a premium cost versus what a

tax penalty would be. The group will be reviewing that information along with the slides from Mr. Miller and the latitude of the options in attempting to develop the appropriate protocols that will protect HHC's patients and incentivize individuals to enroll in the Exchanges.

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

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

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS KRISTA OLSON

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

Mr. Rosen asked if the negative variance was attributable to the timing of the DSH payments. Ms. Olson stated that HHC is expecting an additional $520 million next April 2014. However, compared to last year in total of $1.1 billion that included the "spend-up" this year without that one-time adjustment the expected total projection is $866 million. Continuing with the reporting, current actuals versus the budget are down by $79 million in inpatient receipts due to a decline in the Medicaid fee-for-service down by $49.7 million; Medicaid managed care down by $21.7 million and Medicare by $7.7 million. Outpatient receipts are down by $33 million and all other is up $5 million. Expenses were over budget by $5.3 million due to the transitioning at Coler/Goldwater. Fringe benefits were $2.4 million better due to a FICA refund. OTPS was $38 million worse than budget due in

part to payments made for the restoration of services at Bellevue, Coney Island and Coler due to the storm last year.

ACTION ITEM **LINDA DEHART**

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

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

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

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

INFORMATION ITEM **JAY WEINMAN**
STATEMENT OF REVENUES & EXPENSES as of September 2013 & 2012

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

(OTPS) increased by $51 million of which $36 million was related to an increase in MetroPlus services cost and HHC expenses of $10 million that was a carryover from last year. Medical and non-medical services increased by $2 million.

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

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

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

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

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

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

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 11:10 a.m.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENT REPORTS

KEY INDICATORS
FISCAL YEAR 2014 UTILIZATION

Year to Date
November 2013

NETWORKS	UTILIZATION						AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	VISITS			DISCHARGES/DAYS						
	FY 14	FY 13	VAR %	FY 14	FY 13	VAR %	ACTUAL	EXPECTED	FY 14	FY 13
North Bronx										
Jacobi	176,300	180,968	-2.6%	8,501	7,910	7.5%	5.7	5.9	1.0265	1.0941
North Central Bronx	83,384	89,633	-7.0%	2,042	3,333	-38.7%	5.4	5.8	0.9183	0.7273
Generations +										
Harlem	142,507	123,802	15.1%	4,667	4,638	0.6%	5.5	5.8	0.9842	0.9451
Lincoln	232,219	224,599	3.4%	10,019	9,624	4.1%	4.6	5.3	0.8617	0.8909
Belvis DTC	23,103	24,205	-4.6%							
Morrisania DTC	34,520	32,625	5.8%							
Renaissance	21,203	23,653	-10.4%							
South Manhattan										
Bellevue	239,484	206,083	16.2%	9,827	8,253	19.1%	6.4	6.3	1.1534	1.1257
Metropolitan	165,085	170,646	-3.3%	4,935	5,037	-2.0%	4.5	5.1	0.7823	0.8108
Coler				113,657	103,932	9.4%				
Goldwater				54,858	117,915	-53.5%				
Gouverneur - NF				18,873	21,881	-13.7%				
Gouverneur - DTC	115,695	100,351	15.3%							
HJ Carter										
North Central Brooklyn										
Kings County	290,265	295,025	-1.6%	9,538	10,475	-8.9%	6.7	6.1	1.0381	0.9631
Woodhull	206,645	193,272	6.9%	5,433	5,777	-6.0%	4.9	5.0	0.8289	0.8165
McKinney				47,901	47,609	0.6%				
Cumberland DTC	35,973	36,756	-2.1%							
East New York	30,896	31,098	-0.6%							
Southern Brooklyn / S I										
Coney Island	141,859	120,119	18.1%	5,693	5,772	-1.4%	6.6	6.1	1.0299	1.0714
Seaview				45,704	45,477	0.5%				
Queens										
Elmhurst	260,778	271,153	-3.8%	9,350	10,234	-8.6%	5.4	5.2	0.8906	0.9316
Queens	173,002	168,780	2.5%	5,093	5,370	-5.2%	5.7	5.3	0.8918	0.9084
Discharges/CMI-- All Acutes				75,098	76,423	-1.7%			0.9606	0.9521
Visits-- All D&TCs & Acutes	2,372,918	2,292,768	3.5%							
Days-- All SNFs				280,993	336,814	-16.6%				

Notes:

Utilization

Acute: discharges excl. psych and rehab; reimbursable visits include clinics, emergency department and ambulatory surgery
D&TC: reimbursable visits
LTC: SNF and Acute days

All Payor CMI

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

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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

KEY INDICATORS

FISCAL YEAR 2014 BUDGET PERFORMANCE ($s in 000s)

Year to Date
November 2013

NETWORKS	FTE's VS 6/15/13	RECEIPTS actual	RECEIPTS better / (worse)	DISBURSEMENTS actual	DISBURSEMENTS better / (worse)	BUDGET VARIANCE better / (worse)	
North Bronx							
Jacobi	34.5	$ 208,655	$ (12,696)	$ 213,486	$ (1,458)	$ (14,154)	-3.3%
North Central Bronx	(0.5)	68,152	(9,165)	67,880	11,656	2,491	1.6%
	34.0	$ 276,806	$ (21,861)	$ 281,365	$ 10,198	$ (11,663)	-2.0%
Generations +							
Harlem	(39.0)	$ 128,466	$ (5,996)	$ 128,582	$ (1,579)	$ (7,575)	-2.9%
Lincoln	(38.0)	193,021	(6,734)	187,745	(4,105)	(10,839)	-2.8%
Belvis DTC	1.0	7,836	(560)	6,060	743	183	1.2%
Morrisania DTC	1.5	10,239	(295)	9,775	1,325	1,031	4.8%
Renaissance	(1.5)	5,344	(977)	8,149	(118)	(1,095)	-7.6%
	(76.0)	$ 344,907	$ (14,561)	$ 340,311	$ (3,734)	$ (18,295)	-2.6%
South Manhattan							
Bellevue	25.5	$ 263,687	$ (23,278)	$ 288,575	$ (16,929)	$ (40,207)	-7.2%
Metropolitan	(9.0)	123,369	(3,021)	115,743	5,626	2,605	1.1%
Coler	(4.0)	23,446	(6,393)	52,358	(9,326)	(15,719)	-21.6%
Goldwater	(162.0)	27,629	(16,020)	62,455	(22,242)	(38,262)	-45.6%
Gouverneur	9.5	30,131	(1,582)	34,165	110	(1,471)	-2.2%
HJ Carter	0.0	0	(0)	0	0	(0)	0.0%
	(140.0)	$ 468,261	$ (50,294)	$ 553,297	$ (42,761)	$ (93,055)	-9.0%
North Central Brooklyn							
Kings County	68.5	$ 275,896	$ (11,147)	$ 262,063	$ 3,552	$ (7,595)	-1.4%
Woodhull	37.0	144,097	(15,395)	154,756	(6,892)	(22,287)	-7.3%
McKinney	0.5	15,488	1,577	17,531	(392)	1,184	3.8%
Cumberland DTC	(7.0)	8,830	(1,755)	11,600	1,661	(94)	-0.4%
East New York	6.0	7,998	(1,666)	9,130	(234)	(1,900)	-10.2%
	105.0	$ 452,308	$ (28,387)	$ 455,079	$ (2,305)	$ (30,692)	-3.3%
Southern Brooklyn/SI							
Coney Island	41.0	$ 124,234	$ (10,369)	$ 137,113	$ (863)	$ (11,232)	-4.1%
Seaview	(11.0)	16,110	2,314	19,931	(557)	1,757	5.3%
	30.0	$ 140,344	$ (8,055)	$ 157,044	$ (1,420)	$ (9,475)	-3.1%
Queens							
Elmhurst	2.0	$ 222,699	$ (6,574)	$ 209,086	$ 4,388	$ (2,186)	-0.5%
Queens	1.0	142,272	(5,943)	139,851	(4,769)	(10,711)	-3.8%
	3.0	$ 364,971	$ (12,516)	$ 348,937	$ (381)	$ (12,897)	-1.8%
NETWORKS TOTAL	**(44.0)**	**$ 2,047,599**	**$ (135,675)**	**$ 2,136,033**	**$ (40,403)**	**$ (176,079)**	**-4.1%**
Central Office	70.0	38,960	1,673	115,523	746	2,419	1.6%
HHC Health & Home Care	7.0	5,648	(6,492)	14,650	(3,044)	(9,536)	-40.2%
Enterprise IT	20.5	7,455	1,455	75,340	5,618	7,072	8.1%
GRAND TOTAL	**53.5**	**$ 2,099,661**	**$ (139,040)**	**$ 2,341,547**	**$ (37,083)**	**$ (176,123)**	**-3.9%**

Notes:
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As of November 2013, all services at Coney Island have not been fully restored.

Residents and Grants are included in the reported FTEs. Reported FTEs are compared to 6/15/13.

New York City Health & Hospitals Corporation
Cash Receipts and Disbursements (CRD)
Fiscal Year 2014 vs Fiscal Year 2013 (in 000's)
TOTAL CORPORATION

	Month of November 2013			Fiscal Year To Date November 2013		
	actual 2014	actual 2013	better / (worse)	actual 2014	actual 2013	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 58,590	$ 63,710	$ (5,120)	$ 345,905	$ 372,351	$ (26,445)
Medicaid Managed Care	53,371	43,433	9,939	268,579	261,711	6,868
Medicare	44,340	47,542	(3,203)	211,416	230,659	(19,242)
Medicare Managed Care	21,833	21,377	456	112,935	95,804	17,131
Other	16,790	16,589	201	93,878	91,439	2,439
Total Inpatient	$ 194,924	$ 192,651	$ 2,273	$ 1,032,714	$ 1,051,962	$ (19,248)
Outpatient						
Medicaid Fee for Service	$ 12,291	$ 19,317	$ (7,027)	$ 93,465	$ 80,340	$ 13,125
Medicaid Managed Care	27,705	35,687	(7,982)	241,981	155,561	86,419
Medicare	4,240	4,778	(539)	19,919	24,206	(4,287)
Medicare Managed Care	14,645	9,044	5,601	45,330	36,696	8,634
Other	10,712	10,813	(101)	73,354	57,819	15,535
Total Outpatient	$ 69,593	$ 79,640	$ (10,047)	$ 474,049	$ 354,622	$ 119,427
All Other						
Pools	$ 15,129	$ 6,233	$ 8,896	$ 128,338	$ 208,791	$ (80,453)
DSH / UPL	193,600	-	193,600	345,600	624,100	(278,500)
Grants, Intracity, Tax Levy	9,442	15,806	(6,364)	92,891	96,619	(3,728)
Appeals & Settlements	(2,386)	8,432	(10,818)	4,550	(1,280)	5,830
Misc / Capital Reimb	3,377	5,362	(1,985)	21,519	27,589	(6,070)
Total All Other	$ 219,162	$ 35,833	$ 183,329	$ 592,898	$ 955,819	$ (362,921)
Total Cash Receipts	**$ 483,679**	**$ 308,124**	**$ 175,555**	**$ 2,099,661**	**$ 2,362,403**	**$ (262,743)**
Cash Disbursements						
PS	$ 191,139	$ 190,099	$ (1,041)	$ 1,019,052	$ 1,037,181	$ 18,129
Fringe Benefits	59,070	43,603	(15,467)	362,540	286,978	(75,562)
OTPS	108,737	96,243	(12,495)	559,983	483,203	(76,780)
City Payments	-	-	0	-	141,363	141,363
Affiliation	76,152	75,742	(410)	372,170	377,992	5,822
HHC Bonds Debt	2,876	18,605	15,729	27,803	49,981	22,178
Total Cash Disbursements	**$ 437,975**	**$ 424,292**	**$ (13,683)**	**$ 2,341,547**	**$ 2,376,697**	**$ 35,150**
Receipts over/(under) Disbursements	**$ 45,705**	**$ (116,168)**	**$ 161,872**	**$ (241,886)**	**$ (14,294)**	**$ (227,592)**

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New York City Health & Hospitals Corporation
Actual vs. Budget Report
Fiscal Year 2014 (in 000's)
TOTAL CORPORATION

	Month of November 2013			Fiscal Year To Date November 2013		
	actual 2014	budget 2014	better / (worse)	actual 2014	budget 2014	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 58,590	$ 81,544	$ (22,954)	$ 345,905	$ 418,538	$ (72,632)
Medicaid Managed Care	53,371	58,768	(5,396)	268,579	295,706	(27,127)
Medicare	44,340	39,157	5,182	211,416	213,927	(2,511)
Medicare Managed Care	21,833	19,395	2,439	112,935	106,166	6,769
Other	16,790	18,027	(1,237)	93,878	99,011	(5,133)
Total Inpatient	$ 194,924	$ 216,891	$ (21,967)	$ 1,032,714	$ 1,133,348	$ (100,634)
Outpatient						
Medicaid Fee for Service	$ 12,291	$ 16,277	$ (3,986)	$ 93,465	$ 110,027	$ (16,562)
Medicaid Managed Care	27,705	31,704	(3,999)	241,981	247,972	(5,991)
Medicare	4,240	5,874	(1,635)	19,919	32,308	(12,389)
Medicare Managed Care	14,645	11,411	3,234	45,330	44,312	1,018
Other	10,712	11,867	(1,155)	73,354	79,626	(6,272)
Total Outpatient	$ 69,593	$ 77,133	$ (7,540)	$ 474,049	$ 514,246	$ (40,197)
All Other						
Pools	$ 15,129	$ 14,987	$ 142	$ 128,338	$ 129,490	$ (1,152)
DSH / UPL	193,600	193,600	(0)	345,600	345,600	(0)
Grants, Intracity, Tax Levy	9,442	11,573	(2,131)	92,891	95,197	(2,307)
Appeals & Settlements	(2,386)	(2,851)	465	4,550	(7,187)	11,737
Misc / Capital Reimb	3,377	5,092	(1,715)	21,519	28,007	(6,487)
Total All Other	$ 219,162	$ 222,401	$ (3,239)	$ 592,898	$ 591,107	$ 1,791
Total Cash Receipts	**$ 483,679**	**$ 516,425**	**$ (32,746)**	**$ 2,099,661**	**$ 2,238,701**	**$ (139,040)**
Cash Disbursements						
PS	$ 191,139	$ 190,128	$ (1,011)	$ 1,019,052	$ 1,012,734	$ (6,318)
Fringe Benefits	59,070	59,354	284	362,540	365,185	2,646
OTPS	108,737	110,545	1,808	559,983	523,592	(36,391)
City Payments	-	-	0	-	-	0
Affiliation	76,152	76,485	332	372,170	374,149	1,979
HHC Bonds Debt	2,876	2,961	85	27,803	28,804	1,001
Total Cash Disbursements	**$ 437,975**	**$ 439,473**	**$ 1,498**	**$ 2,341,547**	**$ 2,304,464**	**$ (37,083)**
Receipts over/(under) Disbursements	**$ 45,705**	**$ 76,952**	**$ (31,247)**	**$ (241,886)**	**$ (65,763)**	**$ (176,123)**

Notes:
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