AGENDA

FINANCE COMMITTEE

MEETING DATE: OCTOBER 13, 2015
TIME: 9:00 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER — BERNARD ROSEN

ADOPTION OF THE SEPTEMBER 8, 2015 MINUTES

SENIOR VICE PRESIDENT'S REPORTS — MARLENE ZURACK

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS — KRISTA OLSON/FRED COVINO

INFORMATION ITEM

ICD-10 REVENUE CYCLE IMPLEMENTATION PROJECT — LAURA FREE
ROBERT MELICAN

OLD BUSINESS
NEW BUSINESS
ADJOURNMENT — BERNARD ROSEN

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on September 8, 2015 in the 5th floor Board Room with Bernard Rosen presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Bernard Rosen
Ramanathan Raju, MD
Josephine Bolus, RN
Mark Page
Steven Newmark (representing Deputy Mayor Lilliam Barrios-Paoli in a voting capacity)
Steven Banks, Commissioner, Human Resources

OTHER ATTENDEES

J. Cassidy, Analyst, NYC OMB
T. DeRubio, Analyst, OMB
K. Cherny, Unit Head, OMB
J. DeGeorge, Analyst, State Comptroller's Office
M. Dolan, Senior Assistant Director, DC 37
K. Fedele, Director, Citigroup
M. Henning, Director, Citigroup
M. Hecht, Analyst, NYC
E. Kelly, Health Analyst, IBO
R. McIntyre, Account Executive, Cerner
K. Raffaele, Analyst, OMB
J. Wessler

HHC STAFF

M. Beverley, Assistant Vice President, Corporate Finance
M. Brito, CFO, Coler/Hank Carter Specialty Hospital & Skilled Nursing Facility
L. Brown, Senior Vice President, Corporate Planning, Community Health & Intergovernmental Relations

T. Cartisle, Associate Executive Director, Corporate Planning
D. Cates, Chief of Staff, Board Affairs
D. Collington, Associate Executive Director, Coney Island Hospital
E. Cosme, CFO, Gouverneur Specialty Care Facility
C. Constantino, Senior Vice President, Queens Health Network
F. Covino, Corporate Budget Director, Corporate Budget
J. Cuda, CFO, MetroPlus Health Plan, Inc
S. Fass, Assistant Vice President, Corporate Planning Services
V. Fleming, Director, Corporate Office of Medical Affairs
L. Free, Assistant Vice President, Corporate Managed Care
G. Guilford, Assistant Vice President, Office of the Senior Vice President/Finance/Managed Care
K. Garramone, CFO, North Bronx Health Care Network
T. Green, CFO, Metropolitan Hospital Center
C. Jacobs, Senior Vice President, Patient Safety/Accreditation
J. John, Corporate Comptroller, Corporate Comptroller's Office
L. Johnston, Senior Assistant Vice President, Medical & Professional Affairs
M. Katz, Senior Assistant Vice President, Corporate Revenue Management
A. Kilbert, Resident, Elmhurst Hospital Center
K. Kolodziejski, Assistant Director, Workforce Development
P. Lockhart, Secretary to the Corporation, Office of the Chairman
P. Lok, Director, Corporate Reimbursement Services/Debt Financing
J. Maese, Chief Medical Officer, Southern Brooklyn/Staten Island Health Network
N. Mar, Director, Corporate Reimbursement Services/Debt Financing
R. Mark, Chief of Staff, Office of the President
A. Martin, Executive Vice President/COO, Office of the President
K. McGrath, Senior Director, Corporate Communications
A. Mirdita, CFO, PAGNY
A. Moran, CFO, Elmhurst Hospital Center
K. Olson, Assistant Vice President, Corporate Budget
P. Pandolfini, CFO, Staten Island /Southern Brooklyn Network
C. Parjohn, Director, Office of Internal Audits
K. Park, Associate Executive Director, Queens Hospital Center
G. Proctor, Senior Vice President, Central Brooklyn Health Network
A. Rajkumar, Executive Director, Metropolitan Hospital Center
S. Russo, Senior Vice President/General Counsel, Office of Legal Affairs
C. Samms, CFO, Generations Plus/Northern Manhattan Network
A. Saul, CFO, Central Brooklyn Health Care Network
P. Slesarchik, Assistant Vice President, Corporate Labor Relations
B. Stacey, Chief Financial Officer, Queens Health Network
D. Soares, Senior Vice President, Northern Manhattan/Generation+ Hlth Network
A. Wagner, Senior Vice President, Southern Brooklyn/Staten Island Health Network
R. Walker, CFO, North Brooklyn Health Network
W.Walsh, Senior Vice President, North Bronx Health Network
J. Weinman, CFO, South Manhattan Network
R. Wilson, Senior Vice President/Chief Medical Officer, Office of Medical & Professional Affairs
O. Worthy, CFO, Gotham Health, FQHC
M. Zurack, Senior Vice President/CFO, Corporate Finance

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 14, 2015 were approved as submitted.

CHAIR'S REPORT **BERNARD ROSEN**

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

Ms. Zurack informed the Committee that given the number of items on the agenda, the reporting would be limited only to an update of HHC's cash flow. As of September 4, 2015 the Corporation had $315 million or 20 days cash on hand. The Corporation is expecting several large DSH and UPL payments. So far the September payments are on track. Assuming all else goes as planned HHC will end FY16 with 13 days cash on hand. Going forward, HHC will make every effort to ensure that all outstanding payment receipts are on time. The reporting was concluded.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS - KRISTA OLSON/FRED COVINO

Ms. Olson reported that utilization for the end of FY 15 was down slightly from FY 14 in most categories. Billed visits were down by 2.5%; acute visits were down by 2.4% and D&TCs were down by 3.6%. Nursing home days were up by 1.9% compared to last year. The LOS, all of the hospitals with the exception of Coney Island were within the corporate wide average. Coney Island has remained above the average throughout the year. The CMI was up by 1.7% over last year.

Continuing the reporting, Mr. Covino reported that FTEs were up by 1,035. The budget included an increase of 325 FTEs; however, prior to the end of FY 15, approximately 700 employees were converted to full time from per diem status. Going forward this conversion will be included in the global FTE count as a transition from one category to another. However, as part of the reporting it is reflected as an increase. Receipts were $308 million worse than budget. There was a large increase in the month of June due to the UPL receipts totaling $206 million that were less than projected. Disbursements were $100 million worse than budget which was consistent with the trend throughout the second half of FY 15. A comparison of FY 14 to FY 15 actual, receipts were $340 million higher than last year due to an increase of $523 million in DSH and UPL payments and an increase in the MetroPlus risk pool payment of $64 million. These increases were offset by a $196 million reduction in the pools due to the SUBSLIPA payment whereby there was an advancement of a payment in FY 14 that reduced those payments to three compared to four in FY 15. Additionally there was a reduction of $77 million in grants and intracity due to non-recurring HEAL and FEMA funding. Expenses were up by $373 million compared to last year due to an increase in PS expenses of $237 million of which $206 million was for collective bargaining payments. Allowance increased by $21.7 million and FTEs increased by 325 for a value of $12.3 million over the year. Fringe benefits decreased by $20 million compared to last year due to the timing of payments. The equalization payment was deferred with the City of NY of

$39 million as well as retiree payments for health insurance of $16 million. Those two reductions were offset by an increase related to FICA and welfare funds payments for CB. OTPS payments were up by $124 million due to an increase in purchased services totaling $36 million; $28 million increase in pharmaceuticals due to an increase in generic drugs and the restatement of the 340B policy; other professional services increased by $25 million; and medical surgical supplies increased by $19 million. Affiliation expenses increased by $32 million of which $10 million was related to prior year payments for recalculations at Queens and Bellevue hospitals. An $8.7 million interim payments for collective bargaining as well as $4.5 million for performance indicators at Queens Hospital and PAGNY. The budget compared to actual, inpatient receipts were down by $92.5 million due to a decline in workload; Medicaid fee-for-service was down by $52 million due to a decrease in paid Medicaid discharges of 2,400 or $32 million; a decrease of 25,000 chronic days or $20 million. Outpatient receipts were up by $16.7 million due an increase in the MetroPlus risk pools. All other was down by $232 million due to the reduction in UPL of $206 million. Expenses were on budget; fringe benefits were less than budget by $26 million due to the deferred equalization payment with NYC. OTPS expenses were $133 million worse than budget due to the previous stated increase in the various expense categories. Affiliation expenses were $8 million less than budget due to a delay in the settlement for prior years.

ACTION ITEM **MARLENE ZURACK**

Amending a previously adopted resolution to Increase the authorization for one or more borrowings in an aggregate not to exceed amount from $60,000,000 to $120,000,000 and to expand the scope of allowable uses to include non-equipment capital projects.

Ms. Zurack stated that there had been ongoing discussions over the years regarding HHC's problem with doing its own borrowing. In prior years HHC would issue bonds, create a project fund that would receive interest through what is called guaranteed interest contract (GIC) and that interest would be at as much as or higher than the interest paid on the borrowing. Today this is no longer an option. Consequently, HHC has been exploring more efficient ways of borrowing in order not to pay interest on the debt while earing very little interest on a project fund. After an extensive search, a resolution was present to the Committee for the flexibility to borrow up to $60 million for equipment and now with a commitment from another bank, HHC has secured an additional $60 million for non-equipment and more flexible borrowing which is the requested action of the noted resolution that is requesting the approval of the Board to increase the $60 million to $120 million to allow HHC to borrow and additional $60 million for the noted purposes. Essentially, HHC would have the capacity to borrow in the short term and then after borrowing up to a certain amount and issue bonds to pay itself back which would resolve the problem with the project funds and the resolution would allow HHC the flexibility to do that.

Mr. Page asked after the funds are used for the facilities' equipment needs what would be the term of the final payment on the borrowed amount.

Ms. Zurack stated that the equipment loan which is done and the other will be done upon approval by the Board; therefore, the points are not yet known given that it is yet to be done. The one that was done, for each tranche the term is five years from that tranche. The first year is variable and the last four years are fixed.

Mr. Page stated that it would be five years on the equipment and the additional $60 million would cover more categories other that equipment and it is expected to be similar in term of the five-year agreement.

Ms. Zurack stated that a three year term is currently being explored that would be cheaper and HHC is planning to issue bond in the future.

Mr. Page asked what would be the combination of the facilities and bonds. Ms. Zurack stated that it would depend on the life of the equipment, but an estimate would be 11-12 years.

Mr. Page asked if the miscellaneous items would have a longer useful life than the equipment and whether the terms of the financing structure reflected that.

Ms. Zurack stated that corporate finance would be seeking input from the Committee as HHC gets closer to structuring and finalizing the deal.

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

INFORMATION ITEM **FRED COVINO**
GLOBAL FTE

Mr. Covino stated that the presentation would cover the definition of the global FTE, the benchmarks setting, level as of June 2015 and the targets for FY 16. In defining the global FTE it captures all type of work performed by employees, affiliates, and temporary service workers. The goal is to bring all of those categories together into a single indicator in order to fully define the total levels of staffing at the facilities. The global FTE includes salaried staff, hourly, per diem staff (allowances), overtime converted to FTEs, the affiliate staff and agency staff conversions are based on the number of hours worked.

Mr. Rosen asked if agency nurses used to cover shortage at the facilities were included. Mr. Covino stated that they were included based on the number of hours worked. The caps were calculated by benchmarking the FTEs based on the facilities workload, utilization, casemix and the gross revenues to calculate the facilities' staffing levels based on their productivity. Although workload has declined over the years the FTEs have not followed that trend and has resulted in a slight decline in productivity. A

global FTE reduction target of 1,000 FTEs was set to align with the previous levels of productivity to be achieved over an 18-month period which began last January.

Mrs. Bolus asked if the staff assigned to the various outsourced management contractors, Crothall and JCI were included.

Mr. Covino stated that all of the HHC employees assigned to those contractors were included; however, the management staff was not given that they are directly related to the contracts and therefore were not included.

Mrs. Bolus asked in what category that staff would be included.

Ms. Covino stated that those staff are full time and part time employees and would be across the various categories.

Ms. Zurack interjected that they would be included. Mr. Covino added that HHC staff would be included but the managers were not given that they were outsourced. The metric will be updated during the year to reflect changes in workload and CMI that may result in some changes to the facilities resulting in an adjustment in the current level of reduction if there are improvements in workload and there is an increase in the level of acuity.

Mr. Rosen asked if the reduction of the 1,000 FTEs began in January 2015 to which Mr. Covino responded in the affirmative. The actual global FTE as of June 30, 2015 was 75% of HHC staffing, full time and part time employees; 11% affiliate staff; 5% per diems; 3% allowances; approximately 4% overtime; 3% agency; 4% non-nursing.

Mr. Rosen asked if the majority of the overtime was related to patient care. Mr. Covino stated that it was with the bulk of the usage in nursing. The global FTE target reduction for FY 16 is based on a baseline of 45,704 FTEs with a goal to reduce that level to 44,704 by 6/30/16. The global PS baseline includes in addition to the dollars, fringe benefits as well and there is a global reduction of $100 million that is scheduled for the current FY 16 and will be included in the budget as part of the reporting each month against that target.

Ms. Zurack stated that although there is global FTE cap, the facilities have the flexibility to manage within those resources; therefore, it is actually the global PS that will be the focus of the monitoring.

Mr. Rosen added that it could be argued that the $100 million is high but it includes fringe benefits, etc.

Mrs. Bolus asked if correctional health services were includes. Ms. Zurack stated that those costs and grants were not included. If a facility gets a new grant that would fully fund the program it would not be subjected to the process but rather it would be added.

Mr. Covino added that an example would be the World Trade Center grant that is currently increasing staff due to an increase in volumes at Bellevue. That increase would be added to the target and budget.

Commissioner Banks asked if there would be projected savings in non-PS and whether those savings would be counted against that target.

Ms. Zurack stated that only the non-PS that is being included were the temps and labor staffing. The overall budget must also be achieved in addition to a revenue target which poses a challenge as well.

Mr. Rosen added that the target is based on the actual dollars and the FTEs are basically a way of achieving that dollar reduction.

Ms. Zurack stated that there is an OTPS reduction and a supply chain target. In HHC's financial plan there is a $300 million in savings of which the $100 million is only a portion of that amount. There is a revenue and OTPS targets that are more aggressive than the dollar target.

Mrs. Bolus added that it will be a difficult target to achieve. To which Ms. Zurack agreed. The reporting was concluded.

INFORMATION ITEM **KRISTA OLSON**
PAYOR MIX REPORTS

Ms. Olson reported that the Payor Mix Reports for the end of FY 15 showed that the improvements that were achieved during the year were sustained, a reduction in the uninsured and an increase in Medicaid. The reduction in Bellevue which was a significant decrease was due to a direct Medicaid billing of the prison health population whereby, in prior years the billing was done by HRA. Lincoln hospital was down by 1.5% in its uninsured rate and Woodhull was down by 2%. The Exchanges began the 2nd quarter of last year; therefore, the report was not a pure comparison of the pre-imposed Affordable Care Act (ACA) but rather showed the continuation of the impact of the Exchanges which may be due to the timing relative to the enrollment process that changed as well as the overall eligibility. The outpatient adult payor mix showed that there was a slight increase in Medicaid and Medicare along with a 2% increase in commercial resulting in a reduction in the uninsured of 2.7%. The outpatient pediatrics showed a slight increase in the non CHP commercial plans that resulted in a 1% reduction in the self-pay uninsured. There was less opportunity for children under the ACA but there has been continuous improvement.

Mr. Rosen asked if there has been progressive improvements. Ms. Olson stated that there has been improvement throughout the year and it was sustained. The reporting was concluded.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 9:38 a.m.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS

KEY INDICATORS
FISCAL YEAR 2016 UTILIZATION

Year to Date August 2015

NETWORKS	UTILIZATION						AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	VISITS			DISCHARGES/DAYS						
	FY 16	FY 15	VAR %	FY 16	FY 15	VAR %	ACTUAL	EXPECTED	FY 16	FY 15
North Bronx										
Jacobi	63,071	70,120	-10.1%	2,952	3,298	-10.5%	6.1	6.6	1.0305	0.9436
North Central Bronx	33,540	33,210	1.0%	1,107	702	57.7%	4.7	4.8	0.6887	0.8459
Generations +										
Harlem	49,548	50,680	-2.2%	2,028	1,992	1.8%	5.5	6.1	0.9309	0.9306
Lincoln	85,809	89,592	-4.2%	3,794	3,864	-1.8%	4.8	5.5	0.8433	0.8017
Belvis DTC	8,937	8,704	2.7%							
Morrisania DTC	13,148	12,771	3.0%							
Renaissance	6,898	7,315	-5.7%							
South Manhattan										
Bellevue	94,261	95,630	-1.4%	3,990	4,008	-0.4%	7.4	6.6	1.1220	1.0730
Metropolitan	65,600	67,065	-2.2%	1,726	1,339	28.9%	5.0	5.4	0.7716	0.8856
Coler				45,209	46,044	-1.8%				
H.J. Carter				19,144	19,268	-0.6%				
Gouverneur - NF				12,558	12,240	2.6%				
Gouverneur - DTC	40,036	44,440	-9.9%							
North Central Brooklyn										
Kings County	112,256	117,158	-4.2%	3,609	3,690	-2.2%	6.2	6.3	0.9973	1.0155
Woodhull	77,699	81,367	-4.5%	1,697	2,034	-16.6%	4.9	5.4	0.9331	0.8250
McKinney				18,985	19,240	-1.3%				
Cumberland DTC	11,982	14,019	-14.5%							
East New York	11,986	12,672	-5.4%							
Southern Brooklyn / S I										
Coney Island	57,938	57,876	0.1%	2,357	2,641	-10.8%	7.2	6.5	0.9770	0.9576
Seaview				18,419	18,472	-0.3%				
Queens										
Elmhurst	78,536	104,462	-24.8%	3,349	3,492	-4.1%	6.0	5.6	0.8888	0.8879
Queens	63,847	65,656	-2.8%	2,009	2,100	-4.3%	5.3	5.4	0.7853	0.8085
Discharges/CMI-- All Acutes				28,618	29,160	-1.9%			0.9332	0.9223
Visits-- All D&TCs & Acutes	875,092	932,737	-6.2%							
Days-- All SNFs				114,315	115,264	-0.8%				

Notes:

Utilization

Acute: discharges exclude 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 New York State APR-DRGs version 32.

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 2016 BUDGET PERFORMANCE ($s in 000s)

Year to Date August 2015

NETWORKS	GLOBAL FTEs			RECEIPTS		DISBURSEMENTS		BUDGET VARIANCE	
	Jun 15	Aug 15	Target	actual	better / (worse)	actual	better / (worse)	better / (worse)	
North Bronx									
Jacobi	4,189	4,261		$ 77,763	$ (3,059)	$ 138,543	$ (6,214)	$ (9,274)	-4.4%
North Central Bronx	1,391	1,401		28,430	(130)	41,978	366	236	0.3%
	5,580	5,662	5,608	$ 106,193	$ (3,190)	$ 180,521	$ (5,848)	$ (9,038)	-3.2%
Generations +									
Harlem	3,191	3,214		$ 57,408	$ 4,291	$ 88,963	$ (4,360)	$ (69)	-0.1%
Lincoln	4,197	4,256		87,886	8,841	112,408	(191)	8,650	4.5%
Belvis DTC	141	140		2,959	(454)	3,521	(105)	(559)	-8.2%
Morrisania DTC	261	260		4,084	(290)	5,560	(605)	(895)	-9.6%
Renaissance	174	174		3,488	(471)	3,734	57	(414)	-5.3%
	7,964	8,044	7,359	$ 155,825	$ 11,918	$ 214,186	$ (5,204)	$ 6,714	1.9%
South Manhattan									
Bellevue	5,899	5,979		$ 117,794	$ (1,502)	$ 163,612	$ (6,233)	$ (7,735)	-2.8%
Metropolitan	2,709	2,719		43,382	515	64,936	(4,176)	(3,661)	-3.5%
Coler	1,224	1,235		9,945	(738)	25,762	(1,653)	(2,391)	-6.9%
H.J. Carter	972	996		11,746	(1,135)	33,626	(2,698)	(3,832)	-8.7%
Gouverneur	890	885		12,670	(4,074)	22,361	664	(3,410)	-8.6%
	11,694	11,814	11,585	$ 195,538	$ (6,933)	$ 310,297	$ (14,096)	$ (21,029)	-4.2%
North Central Brooklyn									
Kings County	5,559	5,583		$ 107,273	$ 645	$ 184,567	$ 1,751	$ 2,396	0.8%
Woodhull	3,148	3,141		54,677	3,495	84,090	(4,350)	(855)	-0.7%
McKinney	467	475		6,232	407	8,270	214	621	4.3%
Cumberland DTC	236	236		6,594	10	5,729	(1,057)	(1,047)	-9.3%
East New York	233	245		6,558	(546)	5,916	145	(401)	-3.0%
	9,643	9,680	9,433	$ 181,334	$ 4,011	$ 288,571	$ (3,298)	$ 713	0.2%
Southern Brooklyn/SI									
Coney Island	3,229	3,283		$ 55,603	$ (4,056)	$ 89,269	$ (5,545)	$ (9,601)	-6.7%
Seaview	538	557		6,649	98	9,761	(966)	(867)	-5.7%
	3,767	3,840	3,459	$ 62,252	$ (3,958)	$ 99,030	$ (6,511)	$ (10,469)	-6.6%
Queens									
Elmhurst	4,492	4,492		$ 91,999	$ 1,086	$ 120,725	$ (3,922)	$ (2,836)	-1.4%
Queens	2,918	2,978		54,084	1,240	101,108	(2,601)	(1,360)	-0.9%
	7,410	7,470	7,423	$ 146,082	$ 2,326	$ 221,832	$ (6,523)	$ (4,197)	-1.2%
NETWORKS TOTAL	**46,058**	**46,510**	**44,867**	**$ 847,224**	**$ 4,174**	**$ 1,314,438**	**$ (41,479)**	**$ (37,305)**	**-1.8%**
Central Office	770	777	770	236,594	10,567	62,542	4,298	14,866	5.1%
Care Management	518	542	518	3,212	(3,196)	7,625	(536)	(3,732)	-27.6%
Enterprise IT/Epic	1,060	1,063	1,060	2	(719)	50,802	2,757	2,038	3.8%
GRAND TOTAL	**48,406**	**48,892**	**47,215**	**$ 1,087,033**	**$ 10,826**	**$ 1,435,407**	**$ (34,960)**	**$ (24,133)**	**-1.0%**

Global Full-Time Equivalents (FTEs) include HHC staff and overtime, hourly, temporary and affiliate FTEs. Enterprise IT includes consultants.

Care Management includes HHC Health & Home Care and the Health Home program.

New York City Health & Hospitals Corporation
Cash Receipts and Disbursements (CRD)
Fiscal Year 2016 vs Fiscal Year 2015 (in 000's)
TOTAL CORPORATION

	Month of August 2015			Fiscal Year To Date August 2015		
	actual 2016	actual 2015	better / (worse)	actual 2016	actual 2015	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 80,726	$ 63,083	$ 17,643	$ 163,756	$ 133,615	$ 30,140
Medicaid Managed Care	63,809	53,752	10,056	122,451	107,902	14,549
Medicare	47,177	46,761	416	106,358	107,414	(1,056)
Medicare Managed Care	20,811	22,341	(1,530)	41,976	44,587	(2,612)
Other	18,642	19,600	(957)	35,313	38,963	(3,649)
Total Inpatient	$ 231,165	$ 205,538	$ 25,628	$ 469,854	$ 432,482	$ 37,372
Outpatient						
Medicaid Fee for Service	$ 14,906	$ 10,550	$ 4,356	$ 30,327	$ 25,103	$ 5,224
Medicaid Managed Care	29,612	29,617	(5)	104,861	56,509	48,353
Medicare	5,061	4,926	135	11,041	11,826	(785)
Medicare Managed Care	7,350	7,429	(79)	15,914	14,474	1,440
Other	10,628	12,278	(1,650)	29,014	26,414	2,600
Total Outpatient	$ 67,557	$ 64,801	$ 2,756	$ 191,157	$ 134,325	$ 56,832
All Other						
Pools	$ 5,574	$ 5,374	$ 200	$ 113,014	$ 3,510	$ 109,504
DSH / UPL	-	-	0	-	100,000	(100,000)
Grants, Intracity, Tax Levy	32,357	22,474	9,883	301,134	105,818	195,316
Appeals & Settlements	(747)	(1,454)	707	(3,956)	(3,195)	(762)
Misc / Capital Reimb	9,162	4,827	4,335	15,830	10,405	5,424
Total All Other	$ 46,346	$ 31,220	$ 15,126	$ 426,021	$ 216,539	$ 209,483
Total Cash Receipts	**$ 345,068**	**$ 301,559**	**$ 43,510**	**$ 1,087,033**	**$ 783,345**	**$ 303,687**
Cash Disbursements						
PS	$ 208,974	$ 287,417	$ 78,443	$ 503,793	$ 472,745	$ (31,048)
Fringe Benefits	94,865	59,037	(35,828)	156,921	119,649	(37,271)
OTPS	117,003	110,257	(6,745)	267,846	233,952	(33,894)
City Payments	309,405	-	(309,405)	309,405	-	(309,405)
Affiliation	84,815	75,996	(8,819)	183,447	168,912	(14,535)
HHC Bonds Debt	6,847	6,838	(9)	13,996	13,998	2
Total Cash Disbursements	**$ 821,908**	**$ 539,545**	**$ (282,363)**	**$ 1,435,407**	**$ 1,009,255**	**$ (426,151)**
Receipts over/(under) Disbursements	**$ (476,840)**	**$ (237,986)**	**$ (238,853)**	**$ (348,374)**	**$ (225,910)**	**$ (122,464)**

New York City Health & Hospitals Corporation
Actual vs Budget Report
Fiscal Year 2016 (in 000's)
TOTAL CORPORATION

	Month of August 2015			Fiscal Year To Date August 2015		
	actual 2016	budget 2016	better / (worse)	actual 2016	budget 2016	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 80,726	$ 67,915	$ 12,811	$ 163,756	$ 152,808	$ 10,947
Medicaid Managed Care	63,809	57,889	5,919	122,451	121,362	1,089
Medicare	47,177	40,577	6,600	106,358	99,692	6,666
Medicare Managed Care	20,811	22,748	(1,937)	41,976	47,723	(5,747)
Other	18,642	20,040	(1,398)	35,313	42,921	(7,607)
Total Inpatient	$ 231,165	$ 209,169	$ 21,996	$ 469,854	$ 464,506	$ 5,348
Outpatient						
Medicaid Fee for Service	$ 14,906	$ 13,500	$ 1,406	$ 30,327	$ 30,374	$ (47)
Medicaid Managed Care	29,612	31,883	(2,272)	104,861	105,256	(394)
Medicare	5,061	5,325	(263)	11,041	12,818	(1,778)
Medicare Managed Care	7,350	7,711	(361)	15,914	16,159	(245)
Other	10,628	10,713	(85)	29,014	29,395	(381)
Total Outpatient	$ 67,557	$ 69,132	$ (1,575)	$ 191,157	$ 194,002	$ (2,845)
All Other						
Pools	$ 5,574	$ 7,222	$ (1,648)	$ 113,014	$ 113,607	$ (592)
DSH / UPL	-	-	0	-	-	0
Grants, Intracity, Tax Levy	32,357	41,096	(8,739)	301,134	295,335	5,798
Appeals & Settlements	(747)	-	(747)	(3,956)	(2,627)	(1,329)
Misc / Capital Reimb	9,162	3,146	6,015	15,830	11,383	4,447
Total All Other	$ 46,346	$ 51,465	$ (5,119)	$ 426,021	$ 417,698	$ 8,324
Total Cash Receipts	**$ 345,068**	**$ 329,766**	**$ 15,302**	**$ 1,087,033**	**$ 1,076,206**	**$ 10,826**
Cash Disbursements						
PS	$ 208,974	$ 202,438	$ (6,536)	$ 503,793	$ 500,321	$ (3,472)
Fringe Benefits	94,865	84,620	(10,245)	156,921	155,651	(1,270)
OTPS	117,003	118,752	1,749	267,846	238,415	(29,431)
City Payments	309,405	309,405	0	309,405	309,405	0
Affiliation	84,815	82,759	(2,056)	183,447	183,025	(421)
HHC Bonds Debt	6,847	6,815	(32)	13,996	13,630	(366)
Total Cash Disbursements	**$ 821,908**	**$ 804,789**	**$ (17,119)**	**$ 1,435,407**	**$ 1,400,447**	**$ (34,960)**
Receipts over/(under) Disbursements	**$ (476,840)**	**$ (475,022)**	**$ (1,818)**	**$ (348,374)**	**$ (324,241)**	**$ (24,133)**

INFORMATION ITEM

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

ICD-10

HHC ICD-10 Revenue Cycle Implementation Project

Robert Melican
Laura Free

October 13, 2015

ICD-10 Implementation Early Success

- HHC's bills are being transmitted to payers with ICD-10 codes from both Soarian and Unity

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What is ICD-10?

- On October 1st, the US implemented the use of International Classification of Diseases – tenth edition (ICD-10) codes for documentation of all diagnoses and procedures performed in an inpatient setting and diagnoses only for all outpatient encounters
- While the role of ICD codes as a building block of reimbursement remains unchanged, ICD-10 is a complete overhaul of the coding system
- The US implemented ICD-9 coding in 1979

Why Move to ICD-10?

- ICD-10 was created to:
  - Update coding language to current medical terminology
  - Provide greater specificity to aid research
  - Streamline the process of building procedure codes
- To meet these goals, a new coding structure was created

ICD-10 Section	ICD-9	ICD-10
Diagnosis Codes	14,025	68,105
Procedure Codes	3,800	71,918
Total	**17,825**	**140,023**

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New Coding Approach Means More Specificity – Broken Leg

ICD-9

1 Code

733.16 - Pathologic Fracture of Tibia or Fibula

ICD-10

26 Codes – 1 example below

M80062A - Age Related Osteoporosis with current pathological fracture, left lower leg, initial encounter for fracture

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ICD▶10

ICD-10 Preparations; Began in 2012

- Health Information Management (HIM)
  - Coders, DRG Validators, and Clinical Documentation Improvement Specialist (CDIS) were trained in ICD-10 and have participated in multiple preparedness activities
  - Upgraded 3M software to an Enterprise wide system
- Information Technology – Revenue Cycle Systems
  - Revenue Cycle systems modifications and upgrades
  - Procured the ICD-10 Compass Tool from the Advisory Board Company to inform education of physicians and HIM
- Physician Documentation
  - Educating physicians on changes needed in documentation to permit abstracting with the ICD-10 code set
- Executive Steering Committee
  - Developed programs and provided input on the project plan

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Health Information Management

- All Coders, DRG Validators, and CDIS for IP, ED, Ambulatory Surgery and LTC completed a 40 hour ICD-10 introductory class
- Training goal for HIM was one opportunity per week from September 2014 to go-live to participate in an ICD-10 education or coding session
  - Webinars
  - On-site Seminars
  - Coder Testing
  - Dual Coding Cases

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Health Information Management

- Final ICD-10 preparations concentrated on dual coding, seminars and webinars on the most common diagnoses and procedures at HHC
- Attempted to dual code all cases (coded natively in ICD-10 and 3M software auto translates to ICD-9 codes) by the last week of September
- Provided additional one-day training for DRG Validators and CDIS in September to further prepare HHC's coding and documentation experts; create ICD-10 subject matter experts

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Revenue Cycle and Managed Care

- All Revenue Cycle systems were prepared for the ICD-10 deadline - 3M, Unity, Invision and Soarian
- Payer testing was completed with Medicaid, Medicare, MetroPlus, and HealthFirst
- Renegotiated managed care rates that were paid on the AP-DRG grouper to the APR-DRG or MS-DRG groupers for ICD-10 compliance
- Converted paper encounter forms to ICD-10

Information Technology - QuadraMed

- Training began on September 8th
- Multiple training formats were offered:
  - Classroom one-hour session
  - Computerized Based Training (CBT)
  - Grand Rounds
  - Webinars
- Training focused on managing the patient problem list, new visual indicators, and new top targeted diagnoses selection screens
  - Problem List is now organized by body system: Orthopedics, Pulmonary, Behavioral Health, etc.
  - Changes were recommended by the ICD-10 Physician workgroup
- On-site consultants were at each acute hospital for first 7 days of implementation
- Enterprise Service Desk is primary contact point for resolving QuadraMed issues

Physician Training

ICD-10: It's Here and It's Live
Check the ICD-10 site for useful resources and ICD-10 tipsheets. FULL STORY >

- Executive Steering Committee and hospital leadership recommended multiple service lines receive training
- Specialized sessions were provided to:
  - Medicine, Surgery, Obstetrics, Pediatrics/Newborns, Orthopedics, Behavioral Health, Emergency, Cardiology, Outpatient Clinics and training for new Residents
- ICD-10 trainers conducted 120 sessions at all facilities with over 2,200 attendees from May through September
- Tip cards were developed and distributed to CMOs and HIM weekly for high volume diagnoses
- All training materials are posted on the physician training website accessed through a link on the HHC home page

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ICD-10 Implementation

- Overcame the immediate hurdles:
  - Passing ICD-10 codes between information systems – QuadraMed and 3M to Unity, Soarian and Invision
  - Physician training on ICD-10 coding
- Ongoing ICD-10 efforts:
  - Improve physician documentation in medical records to the greatest level of ICD-10 specificity
  - Code accurately and efficiently
  - Maintain and improve discharged not final billed (DNFB) workload levels

Ongoing ICD-10 Efforts

- Focus on physician documentation improvements and coder accuracy
  - Auditing and monitoring will be ongoing to measure performance through data analysis
  - Training programs for physicians and HIM staff will continue
- Optimize performance of Enterprise Wide 3M
  - Streamline application to improve coding efficiency
  - Produce common set of reports
  - Automate information exchanges to NYS databases
- 5th Pass of the Inpatient Documentation and Coding Value Stream