AGENDA

FINANCE COMMITTEE

MEETING DATE: NOVEMBER 10, 2015
TIME: 9:00 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER — BERNARD ROSEN

ADOPTION OF THE OCTOBER 13, 2015 MINUTES

SENIOR VICE PRESIDENT'S REPORTS — MARLENE ZURACK

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

INFORMATION ITEM

NETWORK BUDGET STATUS PLAN
NORTHERN MANHATTAN/GENERATIONS + — DENISE SOARES

OLD BUSINESS
NEW BUSINESS
ADJOURNMENT — BERNARD ROSEN

MINUTES

MEETING DATE: OCTOBER 13, 2015

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on October 13, 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
L. Garvey, Cerner Corporation
D. Greenberg, Assistant Director, OMB
M. Hecht, Analyst, NYC Comptroller's Office
E. Kelly, Health Analyst, IBO
C. Uber, Senior Budget Analyst, PAGNY
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
E. Casey, 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
V. Fleming, Director, Corporate Office of Medical Affairs
L. Free, Assistant Vice President, Corporate Managed Care
S. Fung, Director, 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
J. Goldstein, Assistant Director, Corporate Planning Services
T. Green, CFO, Metropolitan Hospital Center
J. John, Corporate Comptroller, Corporate Comptroller's Office
M. Katz, Senior Assistant Vice President, Corporate Revenue Management
D. Koster, Assistant Director, Corporate Budget
P. Lockhart, Secretary to the Corporation, Office of the Chairman
P. Lok, Director, Corporate Reimbursement Services/Debt Financing
F. Long, Acting Executive Director, Coler/Henry J. Carter
A. Marengo, Senior Vice President, Corporate Communications/Marketing
R. Mark, Chief of Staff, Office of the President
A. Martin, Executive Vice President/COO, Office of the President
R. Melican, Senior Director, Corporate Managed Care
I. Michaels, Director, Corporate Communications/Marketing
A. Moskos, Director, Office of Facilities (OFD)
J. Nagaraja, Assistant Director, Corporate Managed Care
M. Nunez, Executive Director, Lincoln Medical & Mental Health 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. Ritzel, Associate Director, Kings County Hospital Center
S. Russo, Senior Vice President/General Counsel, Office of Legal Affairs
C. Samms, CFO, Generations Plus/Northern Manhattan Network
J. Santiago, Controller, MetroPlus Health Plan, Inc.
A. Saul, CFO, Central Brooklyn Health Care Network
S. Shaw, Assistant Director, Corporate Budget
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
L. Tulloch, Senior Director, Facilities Development
L. Villalon, Deputy CFO, Coler/Hank Carter Specialty Hospital & Skilled Nursing Facility
A. Wagner, Senior Vice President, Staten Island/Southern Brooklyn Network
R. Walker, CFO, North Brooklyn Health Network
J. Weinman, CFO, South Manhattan Network
R. Wilson, Senior Vice President/Chief Medical Officer, Office of Medical & Professional Affairs
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 September 8, 2015 were approved as submitted.

CHAIR'S REPORT **BERNARD ROSEN**

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

Ms. Zurack informed the Committee that the reporting would include only an update of HHC's cash flow which as of that day, 10/13/2015, the cash on hand was at 12 days; however, there are two large outstanding UPL payments that are scheduled for receipt by the end of the month, October 2015. One has been approved and is in the State's payment cycle and the other is at the approval process phase by CMS. In January 2016 there are some large payments expected and if all goes according to the scheduled plan, with the receipt of those payments, HHC will be able to maintain that level of cash on hand.

Ms. Youssouf asked for clarification of the 12 days of cash on hand through the end of the fiscal year with the receipt of those large payments. Ms. Zurack explained that the cash on hand will increase and the 12 days would be the minimum.

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

Mr. Covino brought to the attention of the Committee that the data for the reporting period represented a small sample size and as such there was a lot of variability which is inherent in the first quarter of the fiscal year.

Ms. Olson stated that the FY 16 utilization through August 2015, the downward trend continued. Billed ambulatory care visits were down by 6.2% compared to 2.5% at year-end FY 15. This is due to a couple of factors; 25% of the visits across HHC are due to a change in the HIV billing whereby counseling is no longer billable; while it occurred during the course of last year it is more dramatic due to a comparison that is reflective of a fully implemented year. Elmhurst is experiencing a lag in closed visits that should be resolve by next month.

Ms. Youssouf asked for an explanation of various negative variances, particularly Jacobi.

Ms. Olson stated that there was a lag in the visits but there was an across the board decrease due to the HIV factor. Discharges were down by 1.9% consist with the decline during last year. At the North Bronx, Jacobi is down but NCB is up due to the shift in the labor and delivery reopening. The decline at Woodhull and Coney Island is due to a large drop in one day stays in conjunction with the variability at the beginning of the year. Nursing home days were down by .8% compared to last year but was a significant improvement over last year's trends. The LOS, a comparison to the corporate-wide average is more vulnerable to variations as noted on the report. Bellevue and Coney Island are showing very large variations. The CMI was up by 1% over last year.

Mr. Covino, continuing with the reporting stated that the reporting reflected a new format in the reporting of the FTEs as part of the global headcount that includes temps, hourlies, and overtime converted to FTEs. The FY 16 current target for FY 16 currently at 48, 892 global FTEs which reflects a 482 increase in FTEs compared to the prior year end level. The increase is primarily in FTEs with a slight increase in overtime offset by a slight reduction in allowance lines. The major increases by title included, 154 tech/spec, 37 art therapist; 28 lab techs; 15 pharmacy techs; 13 social workers; 11 behavioral health techs; 98 aids and orderlies all in patient care techs; 83 environmental positions; 72 residents; 62 clericals. Currently against the target FTEs are up by 1,675 against the year-end target of 47,217. The increase by network included; North Bronx over by 53 FTEs; Northern Manhattan/Generations Plus, over by 686; South Manhattan over by 229; Central Brooklyn over by 247; Staten Island/Brooklyn over by 381; and Queens over by 48.

Mr. Page asked if there is a specific focus on those areas where there are declines in workload and whether there is a qualitative sense of where HHC is going given that the patient population is trending downward but the staffing is increasing.

Mr. Covino stated that there is a focus on reducing the number of temps as part of the Corporation's initiative.

Ms. Youssouf asked for clarification of that focus in relation to the global FTEs as previously reported included the temps. Mr. Covino stated that the global FTE included the temps as part of the total headcount.

Ms. Zurack interjected that the assumption that went into the development of the global FTE target was the movement away from a process base control at central office to a leadership base control at the Network. In terms of the global target, the Networks or local leaderships were informed that the reductions could be achieved through various categories, overtime, attrition and allowances. How that gets achieved must be determined by the Networks/local leaderships. Currently data on benchmarking for comparison purposes is being provided to the hospitals. However, that data shows that the efforts have gone in the wrong direction.

Ms. Youssouf stated that last year the headcount was trending downward and asked if there has been any major changes that triggered that large increase and the increases previously reported by Mr. Covino did not total the 1,675 increase stated in his reporting.

Mr. Covino stated that there has not been any specific change. The 1,700 is what has to be reduced to meet the target compared to what has increased year-to-date.

Mr. Page added that those numbers against the base did not provide any major details of the problem relative to where the increase has occurred.

Mr. Covino stated that based on the percentage of the total target the Networks' targeted reductions are more attainable.

Ms. Zurack stated that the targets include all staffing, affiliation, allowances, overtime converted to FTEs, and is workload driven. The local leaderships must determine how to reduce expenses or

increase the number of patients and increase their market share in order for them to achieve their targets.

Ms. Youssouf asked for clarification of the Network's efforts in increase the number of patients and what that would involve. As part of the workload there is an established ratio of how many employees per workload which should be standard across the Corporation.

Ms. Zurack stated that it was included as part of the budget methodology whereby a ratio of staffing to workload was established by corporate finance.

Ms. Youssouf asked whether it was uniform. Ms. Zurack stated that it was within the acute care hospitals but different within the long term care facilities and the D&TCs within a sector it was uniform.

Dr. Raju stated that as Mr. Covino indicated early, it is too early in the year to make any reliable assumptions. However, in response to earlier questions raised by Mr. Page and Ms. Youssouf, it is important to have the senior leadership in attendance at these meetings given the latitude that allows the local leaderships in making decision about how those targets will be achieved. Going forward the local leaderships will present to the Committee their plans for meeting those targets.

Mrs. Bolus asked when would the ambulatory care be separated from the hospitals and will Gotham have the same as the hospitals.

Dr. Raju stated that effective January 2016 that separation would occur and asked Ms. Zurack to address the Gotham question as it relates to the budget methodology developed by finance.

Ms. Zurack stated that the methodology treated Gotham in one particular way and the ambulatory care at the hospitals in a different way. It was separated by sector. Corporate finance consulted a number of trade associations on how to measure workload and it was more technically based.

Mr. Covino continuing with the reporting stated that receipts were $108 million better than budget while disbursements were $35 million over budget and would be more detailed in the reporting. Cash disbursements and receipts compared to the prior year, inpatient receipts were up by $37.4 million due to an increase in Medicaid fee-for-service, up by $30 million which included $14 million of Meaningful Use funding; Medicaid managed care was also up by $14.5 million. Outpatient was up by $56.8 million of which $48.4 million was for Medicaid managed care due to the MetroPlus risk pool payment that was received in July 2015. All other receipts were up by $209 million due to an increase in City payments that were up by $195 million; $173 million due to tax levy advances for collective bargaining funding and prior year intracity payments. The pools were also up by $109 million due to the timing of FY 15 first SLIPA payment that was prepaid offset by a reduction in DSH which was down by $100 million compared to last year. However, in September 2015, HHC received $201 million in DSH and as previously reported by Ms. Zurack, $600 million in UPL payments are expected in October 2015. City payments were up by $309 million that included payments for the prior FY 14 for medical malpractice, debt service and health insurance payments to the City. Affiliation expenses were up by $14.5 million due to new contracts which included the collective bargaining increases. Bond debt was flat.

Mr. Page asked what drives the issuance of the Medicaid risk pool payment and why was it received at that time.

Mr. Covino stated that based on the utilization within the risk contracts, whereby whatever HHC does not receive as premiums after a small administrative fee from MetroPlus it is the saving on the care.

Mr. Page stated that the question related to the scheduling of those payments relative to whether the payments were scheduled monthly, quarterly, etc.

Ms. Zurack in response to Mr. Page's question stated that it is six months after the end of the fiscal year when MetroPlus is in a position to have enough IBNR worked off to better calculate the number.

Mr. Covino stated that to-date HHC has received the funding earlier due to HHC's cash positon therefore this is not a true surplus. The actual estimate for the risk pool was approximately the same as last it was for last year. This was just an early payment to HHC's due to the cash flow problem.

Ms. Youssouf asked if the City payments of $309 million was the major factor driving the reporting period that had the most impact on the actual. Mr. Covino responded in the affirmative.

Dr. Raju added that those payments were not a negative impact as Ms. Zurack explained last year those payments were delayed as planned and scheduled for payment this FY 16. Dr. Raju asked Ms. Zurack for further clarification.

Ms. Zurack added that the $309 million refers to the FY 14 malpractice and debt service payments which HHC finance based on the pending UPL payments in FY for calendar Year 14 which was recently received in September 2015. Essentially, it is a year and nine months late. One of the UPL payments that was expected was for CY 11. The State and Federal governments were behind in those payments that ultimately impacted HHC's cash flow which HHC managed by delaying those City payments. Therefore, the FY 14 payments were made in August 2015, FY 16. The significance of those delays is that in order for HHC to catchup with the City for those payments HHC must receive those UPL payments from the State and Federal governments.

Ms. Youssouf asked what would be the normal payment. Ms. Zurack stated that an annualized number including EMS would be approximately $475 million constituting three major components, EMS, medical malpractice and debt service with slight fluctuations in each.

Ms. Youssouf asked if HHC has any other outstanding payments other than those previously noted.

Ms. Zurack stated that there is an FY 15 payment of $479 million outstanding.

Mr. Page asked what the projected outstanding amount is for the current FY 16.

Ms. Zurack stated that HHC expects to pay the FY 16 in FY 17. Therefore it will always be a running amount. Mr. Page asked if that amount would be $475 million and whether that amount would be consist with HHC's plan. Ms. Zurack responded in the affirmative adding that except for EMS given that those receipts are not HHC. If HHC makes its plan it would be $300 million assuming that HHC gets caught up on EMS.

Mr. Covino continuing with the reporting stated that the comparison of the budget to the actual, inpatient receipts were up by $5.3 million due to the Medicaid-fee-for-service that included an increase in the Meaningful Use funds of $14 million. Outpatient receipts against the budget were down by $2.8 million due to a reduction in the Medicare actual. All other receipts were up by $8.3 million due to prior year intracity receipts. Miscellaneous receipts were up by $4.4 million due to excess faculty practice receipts from PAGNY was well as the receipt of the 340B funds received in excess of the budget. Expenses, personal services (PS) and fringe benefits were on budget or slightly over budget due to the increase in FTEs. OTPS expenses were $29 million over budget due to an increase in the contracting of professional services of $8 million; purchased services of $7 million; pharmaceutical and medical surgical supplies up by $5 million in payments and bond debt was on budget.

Mr. Page asked if those OTPS services were connected to HHC labor force and the amount of services required.

Mr. Covino stated that it is a totally different requirements in terms of the budget variance which is not due to those temp services.

Ms. Zurack added that it is in the number. Mr. Covino stated that it is in the number but it is not one of the driver of that increase versus the budget. It is consistent with prior year spending.

Ms. Youssouf asked if HHC was affected by the recent news article pertaining to the closing of an ACO in NYS.

Dr. Wilson in response stated that it was not an ACO but rather Health Republic, an insurance plan.

Ms. Youssouf asked if any of HHC patients were insured by that plan.

Ms. Zurack stated that a large number of HHC patients are covered by that plan.

Dr. Raju added that the issue is being address by HHC in that MetroPlus will enroll some of those members.

Ms. Zurack stated that similarly HHC is looking into some of its other partners to pick up as many member as possible as well.

INFORMATION ITEM **LAURA FREE/ROBERT MELICAN**

Ms. Zurack introduced Ms. Free and Mr. Melican to the Committee stating that Mr. Melican was hired to manage the financial portion of the ICD-10 conversion under Ms. Free who is in charge of HHC Managed Care division where Mr. Melican resides.

Ms. Free stated that Mr. Melican has been leading the charge for the ICD-10 and working on HHC's readiness since 2012. The presentation on the Committee's agenda was intended to provide the Committee with an overview of the steps and actions taken by finance as part of that process.

Mr. Melican stated that HHC has overcome the first hurdle and is transmitting bills to payers from both fiscal systems and as of Friday, October 9, 2015, 1,700 claims which is an accomplishment were

submitted. In terms of the Committee understanding ICD-10, what it is and its importance to HHC and the necessary steps taken to meet the requirements of the ICD-10, the entire US moved to a new coding scheme ICD-10 international coding of diseases on October 1, 2015. What has remained constant is that the ICD-10 is the building block for HHC's reimbursement based on the DRGs. The last time the US switched was in 1979. The reason for the change is that the language in 1979 did not fit the current medical terminology greater specificity was needed for today's research. This has translated into a change in the codes from 17,000 to 140,000 due to that specificity, in terms of encounter versus subsequent encounter and how an injury occurred. For example, one code in ICD-9, a broken leg, turns into 26 codes in ICD-10 due to the expansion of the cause, such as why it occurred, where it occurred, whether it was an initial or subsequent encounters noted a lot more documentation is required by the physicians. In terms of how HHC prepared for the change in the ICD-10 coding, there were targeted groups, HIM (health information management), coders; DRG validators and clinicians documentation improvement specialists that required training. There was a need to upgrade all of the software to accommodate all of the new coding from five to seven and educating the physicians on how to meet the new specificity. This was led by the executive steering committee chaired by Ms. Zurack and Sal Guido, Interim CIO, comprised of all of the major divisions, finance, managed care and each facility was represented.

Mrs. Bolus asked how far back HHC would have to go to correct the coding. Ms. Zurack stated that from October 1, 2015; however, there was a need to do some concurrent coding for some period of time.

Ms. Bolus asked if that would pose any problems for HHC. Ms. Zurack stated that Mr. Melican would address that issue in the presentation.

Mr. Melican stated that the first phase focused on how to educate the staff involved in the process. All 200 plus coders were put through an introductory training class. Originally, ICD-10 was scheduled to begin in 2014 but was delayed to 2015. There were onsite webinars twice a month and onsite training seminars every other month. The coders were tested and a process of dual coding cases which Ms. Zurack prefaced or whereby cases were coded in ICD-10 and the computers would back-code them to 2009 in order to give the coders practice as part of the coding efforts.

Ms. Youssouf asked who does the coding. Mr. Melican stated that coding is done by the coders in the HIM department by reading the medical record and abstracting the procedures and diagnosis into a code set through the use of a software from 3M which enables them to get to a code faster by forming a pathway.

Ms. Youssouf asked if it is something that through the EMR implementation will be done automatically. Ms. Zurack stated that it would not.

Mr. Melican stated that there will always be a certified medical record coder reading that medical record.

Mr. Page asked if the medial record was adequate to enable the coder to create the code. Mr. Melican stated that it is and that is the challenge in the ICD-10 to put in place.

Ms. Zurack added that this is a highly regulated field in that the coders are certified. Coders can only code what physicians' document in the record and only physicians can document. Therefore, the coders reviewing the medical records to identify inconsistencies must inform the physicians. The physician has to update the medical record.

Ms. Youssouf asked how often that occurs. Ms. Zurack stated that it occurs constantly.

Mr. Page asked what the time lag is from when the physician has to update the chart from the initial encounter with the patient.

Ms. Zurack stated that based on the information in the chart it is not a question of memory but rather looking at the chart and making the correct note. The case is there and some information may be missing or lacking. There are a number of indicators or factors that come into play that the coders are required to review and question.

Ms. Youssouf asked who certifies the coders. Ms. Zurack stated that it is HIMA.

Dr. Wilson clarified that it is the American Health Information Management Association (AHIMA).

Mr. Rosen asked if there is a crosswalk for converting the old ICD-9 to the new 10.

Ms. Zurack stated that there is a crosswalk.

Mr. Melican stated that there is a software that can do that conversion.

Ms. Zurack stated that the other thing is the elementary piece, HHC has certified or super coders or DRG coders who review the coding after the fact and find things that the coders failed to catch. There are also clinician documentation specialist who are nurses who review the medical records on an ongoing basis who work with the physicians on identifying issues in the charts. It is not only retrospective but in real time as well.

Dr. Raju in response to Ms. Youssouf's questions stated that the outpatient area is coded by the physicians and there is a major difference. It is easier to code and the coders are already trained to code charts, but the residents and physicians are a major challenge and a huge amount of work is needed to get them trained on how to do that level of specificity in the charts.

Mr. Melican stated that the IT component was focused on changing the systems and the handoff of codes one to another and to ensure continual payments. There were tests conducted with some of the major payers, Medicaid, MetroPlus and Medicare. The managed care rates were renegotiated to go to the new ICD-10 compliant grouping, converted payers encounter forms to be compliant. The physicians and the QuadraMed system which was completely updated to accommodate the new code set which was changing the problem with physicians selecting the diagnoses or the problem with the patient's encounter that in terms backup into a code. The physician does not code but selecting the proper diagnoses that links to a code in the QuadraMed system.

Ms. Youssouf asked if the system questions the selection made by the physician through a prompt.

Mr. Melican stated that the physician evolves to that definition through the input into the various medical services. For example, the broken leg the physician would enter orthopedics, the system would ask what bone was broken and that would prompt to the list whereby the physician would then select the code which is where the physicians' education would begin.

Ms. Zurack stated that there are two types of codes done by the physicians, one is the diagnosis code and the procedure code. What Mr. Melican was describing was the procedure code process. The doctors do know the diagnose codes and pick them from a dropdown menu.

Ms. Youssouf asked if that selection was out of the 176,000 codes. Ms. Zurack stated that there is a piece that cues the physician to the most common codes.

Ms. Katz stated that what was done in QuadraMed based on different services; based on the physicians documentation in the charts those common codes are based on the most common diagnose seen in that service; therefore, it is not out of the 176,000 codes but rather the subset of those codes. Over time the patients' problems were grouped and behind that those problems were codes and what was done for ICD-10, all of the problems' that were the patients diagnoses, the ICD-9 codes were converted to the 10.

Mr. Melican stated that on-site for the "go-live," there were consultants in attendance at each facility from White Glove and the Enterprise service desk was used as a point of contact, whereby if any issues arose the physicians were instructed to contact the Enterprise Service desk and assistance would be provided or the HIM staff were on call as well. The physicians' education piece included a lot of on-site in person education that was the best approach on how to document to the ICD-10 level of specificity that resulted in over 120 sessions at each facility on primarily nine specialties with the greatest amount of changes from the ICD-9 to 10. Concentrating on those areas where the greatest difficulty would be. There were tip cards issued to the CMOs to HIM staff and on HHC website all of the pertinent information was made available.

Mr. Rosen asked if all of the current medical record must be recoded.

Ms. Katz stated that it is not the medical record. There is a problem list seen in a particular service such as medicine and each patient had in their records a list of diagnoses in the chart behind the screens. Those written diagnoses had a code attached to them that were in ICD-9 prior to October 1, 2015. Using common files and software those ICD-9 codes were converted to ICD-10 codes where possible. In some instances the 09 code was equal to more than one ICD-10. Therefore, it was not a one for one match. In those instances a coder or physician would need to choose the appropriate code.

Ms. Zurack clarified that the IT contractor in conjunction with the staff did that piece. This is for outpatient where the physician does the coding.

Ms. Youssouf asked how the ICD-10 interacts with the electronic medical record, EPIC given that codes are required.

Ms. Zurack stated that when HHC moves from an electronic medical record to a state of the art electronic health record, it should result in more specificity of what is in the medical records which should improve coding.

Ms. Youssouf asked if in the new electronic medical records system there will be a code associated with the diagnoses.

Ms. Zurack stated it was difficult to answer that question given that the process will include the archiving of the old record until HHC has been on the new record for a while. The new record is an enterprise-wide record. If it is known that a patient has had a chronic condition at one of HHC facilities within the system each facility would know about that condition that should improve treatment and coding but that is only after the Corporation is a whole system and fully up and running on the new EPIC system. Only going forward, overtime it should improve the information available to the physician and the coders. On the outpatient side for Medicaid and Medicare documentation drives coding and coding drives reimbursements but the differences are not as extreme as the inpatient.

Ms. Bolus asked how many diagnoses could a patient have as part of the new ICD-10.

Mr. Melican stated that it could go up to 50 for one person but that would be rare given that it rarely goes above 25.

Ms. Zurack stated that the payers start at 25. There are multiple diagnose for comorbidity conditions. The choices are more but not necessarily more codes. However, the reimbursement is driven by the patient having multiple conditions at the time of the visit. On the outpatient side, there are two codes. Typically but there have been some efforts to get the physicians to do four to five complaints by the patients at the time of the visit.

Dr. Raju stated that if a patients comes in with a broken leg but has other conditions such as diabetics, hypertension, sometimes the physician only documents the broken leg and the hypertension but all of the conditions should be chosen. The problem is that physicians view the treatment as an episodic care only the primary diagnoses is addressed but other conditions exist and should be documented in the chart. This is the major issue with the physicians that is being addressed through the training as part of the ICD-10.

Ms. Zurack stated that as a way of conveying this issue as Mr. Melican indicated, the hospitals have used tip cards that basically state, "Be as specific as possible about the diagnosis." "Be very comprehensive for conditions that are systematic" which makes a significant difference in HHC's reimbursement, managed care premiums, inpatient cases, etc. There has been reinforcement within the HIM departments relative to the coders and validators.

Dr. Raju stated that the major problem is that there needs to be a major change in the mindset of the physicians that would address the lack of documentation in the charts which is a major task and educational effort going forward.

Ms. Youssouf asked if it is expected that the coding changes in the ICD-10 will be at some point audited by the federal government.

Ms. Zurack stated that there is validation on the part of the validators who address the compliance aspect of the coding and software that identifies inconsistencies in documentation and coding and compliance as well. The key is for the documentation to reflect only what was actually done and only code the revenue earned which is emphasized repeatedly as part of the process training.

Ms. Youssouf asked if that software was approved by the federal government or the required authorized regulators.

Mr. Melican stated that the software used is 3M on the inpatient side and QuardraMed on the outpatient side. The 3M software is the largest provider in the country and is fully compliant.

Ms. Zurack stated that 3M got the state contract for the state grouper and therefore it is a requirement for use by the hospitals.

Mr. Rosen asked how long ICD-9 was in existence. Mr. Melican stated that it has been since 1979 to October 2015.

Mr. Rosen asked if the hospitals would be required to use all of the codes in documenting and what is the logic behind the creation of that huge volume of codes.

Dr. Wilson stated that the ICD-10 is an international classification of diseases. It was not established for billing but rather for the purpose of describing illnesses and to epidemiological mapping around the world and is being upgraded due to the inadequacy in describing illnesses and treatment, diagnoses and procedural codes. In the USA, it has been taken as a description for billing purposes but that's not the primary reason for its design. There is a large number of codes inside these codes that may not materially make a big difference to coding. There are other codes that make a huge difference to coding and it depends on which payor better goes through it. The process is that a patient has an interaction a documentation of that interaction occurs in the medical records already a drop in information. Then that information in the medical record is received and translated into codes, a further drop of information and from that point billing is done. In each of those steps there is a reduction. The problem with under coding which is a bigger problem of compliance risk of over coding. Under coding means that HHC will not get the appropriate level of reimbursement but it also means that patients are being described as not being as sick. Therefore, in the epidemiology world where there are CMIs, HHC patients appear less sick than other patients. This whole process as it relates to doing it correctly, if not done the way it should be, HHC will bill less resulting in less revenue. At the current time there are some weak points in this process which this training program and team have done by addressing some of those weak points but some of those weak points consist of whether the physician are documenting the interaction fully and secondly, the question of whether physicians should be doing coding. Although there are fewer codes there are still five million visits compared to 220,000 inpatient discharges. Therefore, in terms of volume there is a major difference. Essentially, HHC has to complete this phase and then rethink how it will do all of these processes. This is a major challenge and a lot of preparation has gone into preparing for this new change in coding.

Mrs. Bolus asked for clarification of reduction stated in Dr. Wilson's overview.

Dr. Wilson stated that all of the information is not being captured that is stated as part of the visit and all that is stated in the records does translate all that was stated in the visit and within the record into a code.

Ms. Zurack stated that the ICD-10 has been around for approximately twenty years.

Dr. Wilson added that in 1997-98 was the first public use of ICD-10.

Ms. Zurack stated that it has been used in other countries for a long time but do not have the type of reimbursement system as HHC. It is not as complicated and has been used for more precise diagnostics but now being used to drive more precise payments.

Mrs. Bolus asked whether it was more time consuming for the physicians or the coders. Ms. Zurack stated that it is more for the coders.

Dr. Wilson added that for physicians this month there has been an issue with the ICD-10 training, Meaningful Use, and E-prescribing all of which increase the amount of time the physicians and to address that issue the schedules have been staggered to allow time to do that, otherwise the patients would be waiting an extremely long time which would not be very patient sensitive. This is a major impact on physicians and what is required of them.

Mr. Melican stated that the future plan include as Dr. Wilson indicated concentrating on improving the physicians documentation and having the coders capture as much as possible as accurately as possible that documentation in the inpatient system; optimizing the system by reviewing the changes and ensuring that the systems are as streamlined as possible and easy for the HIM staff to use and understand where the weaknesses are. There will be a fifth review of the processes in the coming months through a value stream process to concentrate on the progress and evaluate where HHC stand in the ICD-10 process.

Mr. Rosen stated that it would appear that many of those codes will not be used and asked whether some effort would be made to review that in the future so as to easy the role of the physicians.

Mr. Melican stated that a lot of those codes will never be used. However, HHC has a tool that can be used to run its coding through an Advisory Board tool called Compass that allows HHC to compare how it is doing to peer hospitals.

Ms. Youssouf stated that the overall presentation of the process was very impressive in terms of the volume of work involved and how this system works with the electronic health medical record which is of concern in terms of how these systems are being managed.

Dr. Raju asked for confirmation on whether this system would interface with the EPIC system when it goes live. Mr. Melican responded in the affirmative.

Ms. Zurack stated that on the inpatient side it would not.

Dr. Raju clarifying the question and response stated that the ICD-10 coding software will interface with the EPIC system to which Ms. Zurack agreed.

Mrs. Bolus asked that provider be used as a point of reference as oppose to physician.

Dr. Raju stated that the ICD-10 is a huge problem across the country and finance has done a lot of work in pulling this together.

Mr. Melican stated that it was a team effort on behalf of the staff that worked on the project.

Mr. Page asked if when the physician does the initial write up it would be in a language that made sense at that level to avoid repeated translations which is extremely time consuming.

Ms. Zurack stated that what has been observed after reviewing this process, in the future as part of the electronic health record it is important that as the providers are navigating through the screens which are driven by what the providers are doing it is not free text but it drives logically and intuitively so as to avoid having to do the extra work. This is part of the IT vendor to get a system that will do that which will enable better coding better reimbursement and documentation. The presentation was concluded.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 10:15 a.m.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS

KEY INDICATORS
FISCAL YEAR 2016 UTILIZATION

Year to Date
September 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	102,085	106,505	-4.2%	4,401	4,982	-11.7%	6.0	6.4	1.0229	0.9449
North Central Bronx	52,807	51,526	2.5%	1,614	1,022	57.9%	4.5	4.7	0.6902	0.8358
Generations +										
Harlem	78,168	78,140	0.0%	2,978	2,955	0.8%	5.6	6.0	0.9396	0.9242
Lincoln	135,569	137,261	-1.2%	5,522	5,791	-4.6%	4.9	5.4	0.8324	0.8025
Belvis DTC	14,002	13,189	6.2%							
Morrisania DTC	20,219	20,386	-0.8%							
Renaissance	9,832	10,906	-9.8%							
South Manhattan										
Bellevue	142,661	149,857	-4.8%	5,872	6,013	-2.3%	6.6	6.4	1.1330	1.0835
Metropolitan	99,669	103,142	-3.4%	2,546	1,964	29.6%	4.9	5.2	0.7572	0.8823
Coler				66,830	68,399	-2.3%				
H.J. Carter				28,488	28,587	-0.3%				
Gouverneur - NF				18,609	18,445	0.9%				
Gouverneur - DTC	62,151	65,670	-5.4%							
North Central Brooklyn										
Kings County	169,288	175,209	-3.4%	5,446	5,609	-2.9%	6.0	6.1	1.0055	1.0035
Woodhull	120,803	122,282	-1.2%	2,566	3,041	-15.6%	4.9	5.2	0.8759	0.8266
McKinney				28,299	28,501	-0.7%				
Cumberland DTC	18,212	20,400	-10.7%							
East New York	19,421	20,636	-5.9%							
Southern Brooklyn / S I										
Coney Island	90,903	81,744	11.2%	3,496	3,973	-12.0%	7.2	6.4	0.9903	0.9393
Seaview				27,404	27,419	-0.1%				
Queens										
Elmhurst	162,163	157,288	3.1%	4,912	5,232	-6.1%	6.1	5.5	0.8989	0.8736
Queens	108,040	106,902	1.1%	2,961	3,168	-6.5%	5.2	5.2	0.7836	0.7971
Discharges/CMI-- All Acutes				42,314	43,750	-3.3%			0.9338	0.9178
Visits-- All D&TCs & Acutes	1,405,993	1,421,043	-1.1%							
Days-- All SNFs				169,630	171,351	-1.0%				

Utilization

Discharges: exclude psych and rehab

Visits: Beginning with the September 2015 Board Report, FY15 and FY16 utilization will now be based on date of service and HIV counseling visits that are no longer billable have been excluded. Visits continue to include Clinics, Emergency Department and Ambulatory Surgery.

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
September 2015

NETWORKS	GLOBAL FTEs			RECEIPTS		DISBURSEMENTS		BUDGET VARIANCE	
	Jun 15	Sep 15	Target	actual	better / (worse)	actual	better / (worse)	better / (worse)	
North Bronx									
Jacobi	4,189	4,278		$ 123,708	$ (7,211)	$ 181,723	$ (7,532)	$ (14,743)	-4.8%
North Central Bronx	1,391	1,408		44,654	213	55,291	1,819	2,031	2.0%
	5,580	5,686	5,608	$ 168,362	$ (6,999)	$ 237,014	$ (5,713)	$ (12,712)	-3.1%
Generations +									
Harlem	3,191	3,239		$ 91,422	$ 4,105	$ 118,468	$ (6,258)	$ (2,154)	-1.1%
Lincoln	4,197	4,261		130,986	8,102	152,376	1,313	9,415	3.4%
Belvis DTC	141	143		3,474	(554)	4,705	15	(539)	-6.2%
Morrisania DTC	261	259		4,963	(308)	7,620	(599)	(907)	-7.4%
Renaissance	174	175		3,847	(306)	5,273	31	(274)	-2.9%
	7,964	8,077	7,358	$ 234,691	$ 11,038	$ 288,442	$ (5,498)	$ 5,540	1.1%
South Manhattan									
Bellevue	5,899	5,992		$ 187,268	$ (2,313)	$ 225,694	$ (7,933)	$ (10,245)	-2.5%
Metropolitan	2,709	2,733		68,105	(1,066)	89,720	(5,354)	(6,420)	-4.2%
Coler	1,224	1,241		17,203	(1,340)	36,162	(2,289)	(3,630)	-6.9%
H.J. Carter	972	1,000		21,945	(1,845)	43,073	(3,395)	(5,240)	-8.3%
Gouverneur	890	892		16,673	(4,964)	30,556	942	(4,021)	-7.6%
	11,694	11,858	11,596	$ 311,194	$ (11,528)	$ 425,206	$ (18,028)	$ (29,556)	-4.0%
North Central Brooklyn									
Kings County	5,559	5,549		$ 177,549	$ (1,178)	$ 236,993	$ 6,009	$ 4,831	1.1%
Woodhull	3,148	3,163		97,870	5,814	115,632	(4,211)	1,603	0.8%
McKinney	467	476		8,604	132	11,907	558	690	3.3%
Cumberland DTC	236	231		6,852	(660)	7,752	(1,396)	(2,056)	-14.8%
East New York	233	244		7,438	(552)	7,838	311	(241)	-1.5%
	9,643	9,663	9,434	$ 298,313	$ 3,556	$ 380,122	$ 1,271	$ 4,827	0.7%
Southern Brooklyn/SI									
Coney Island	3,229	3,328		$ 80,577	$ (12,823)	$ 121,669	$ (8,472)	$ (21,295)	-10.3%
Seaview	538	549		8,396	(955)	13,833	(1,174)	(2,129)	-9.7%
	3,767	3,877	3,463	$ 88,973	$ (13,778)	$ 135,502	$ (9,646)	$ (23,424)	-10.2%
Queens									
Elmhurst	4,492	4,506		$ 126,751	$ (8,369)	$ 163,019	$ (2,773)	$ (11,142)	-3.8%
Queens	2,918	2,969		84,275	(2,690)	131,130	(3,569)	(6,260)	-2.9%
	7,410	7,475	7,423	$ 211,026	$ (11,059)	$ 294,148	$ (6,342)	$ (17,401)	-3.4%
NETWORKS TOTAL	**46,058**	**46,636**	**44,882**	**$ 1,312,560**	**$ (28,770)**	**$ 1,760,432**	**$ (43,956)**	**$ (72,726)**	**-2.4%**
Central Office	770	784	770	241,401	8,442	76,403	465	8,907	2.9%
Care Management	518	545	518	6,065	(3,376)	11,059	(905)	(4,280)	-21.8%
Enterprise IT/Epic	1,060	1,086	1,060	2	0	70,976	3,474	3,474	4.7%
GRAND TOTAL	**48,406**	**49,051**	**47,230**	**$ 1,560,029**	**$ (23,703)**	**$ 1,918,870**	**$ (40,922)**	**$ (64,625)**	**-1.9%**

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 September 2015			Fiscal Year To Date September 2015		
	actual 2016	actual 2015	better / (worse)	actual 2016	actual 2015	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 64,044	$ 65,838	$ (1,794)	$ 227,800	$ 199,454	$ 28,346
Medicaid Managed Care	52,944	51,446	1,498	175,395	159,348	16,047
Medicare	38,696	37,268	1,428	145,054	144,682	372
Medicare Managed Care	21,122	41,420	(20,298)	63,098	86,007	(22,910)
Other	15,232	19,876	(4,644)	50,546	58,838	(8,293)
Total Inpatient	$ 192,039	$ 215,848	$ (23,809)	$ 661,893	$ 648,329	$ 13,563
Outpatient						
Medicaid Fee for Service	$ 6,472	$ 39,342	$ (32,870)	$ 36,799	$ 64,444	$ (27,645)
Medicaid Managed Care	26,499	45,022	(18,524)	131,360	101,531	29,829
Medicare	4,244	4,975	(731)	15,285	16,801	(1,516)
Medicare Managed Care	6,598	10,217	(3,619)	22,512	24,691	(2,179)
Other	10,714	9,926	788	39,728	36,340	3,387
Total Outpatient	$ 54,526	$ 109,482	$ (54,956)	$ 245,684	$ 243,808	$ 1,876
All Other						
Pools	$ 5,399	$ 15,365	$ (9,965)	$ 118,413	$ 18,875	$ 99,539
DSH / UPL	201,100	43,000	158,100	201,100	143,000	58,100
Grants, Intracity, Tax Levy	10,035	5,444	4,591	311,169	111,262	199,907
Appeals & Settlements	4,084	(1,782)	5,866	128	(4,977)	5,105
Misc / Capital Reimb	5,813	4,982	830	21,643	15,388	6,255
Total All Other	$ 226,431	$ 67,009	$ 159,422	$ 652,453	$ 283,548	$ 368,905
Total Cash Receipts	**$ 472,997**	**$ 392,339**	**$ 80,657**	**$ 1,560,029**	**$ 1,175,685**	**$ 384,344**
Cash Disbursements						
PS	$ 209,439	$ 199,696	$ (9,743)	$ 713,232	$ 672,441	$ (40,791)
Fringe Benefits	72,565	69,890	(2,675)	229,485	189,539	(39,946)
OTPS	110,624	112,832	2,208	378,470	346,784	(31,686)
City Payments	-	-	0	309,405	-	(309,405)
Affiliation	85,021	75,978	(9,043)	268,468	244,890	(23,577)
HHC Bonds Debt	5,814	5,854	40	19,810	19,852	42
Total Cash Disbursements	**$ 483,463**	**$ 464,251**	**$ (19,213)**	**$ 1,918,870**	**$ 1,473,506**	**$ (445,364)**
Receipts over/(under) Disbursements	**$ (10,467)**	**$ (71,911)**	**$ 61,445**	**$ (358,841)**	**$ (297,821)**	**$ (61,020)**

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

	Month of September 2015			Fiscal Year To Date September 2015		
	actual 2016	budget 2016	better / (worse)	actual 2016	budget 2016	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 64,044	$ 67,915	$ (3,870)	$ 227,800	$ 220,723	$ 7,077
Medicaid Managed Care	52,944	60,597	(7,652)	175,395	181,958	(6,563)
Medicare	38,696	39,538	(842)	145,054	139,230	5,824
Medicare Managed Care	21,122	23,802	(2,680)	63,098	71,525	(8,427)
Other	15,232	20,672	(5,440)	50,546	63,593	(13,047)
Total Inpatient	$ 192,039	$ 212,523	$ (20,484)	$ 661,893	$ 677,029	$ (15,137)
Outpatient						
Medicaid Fee for Service	$ 6,472	$ 13,500	$ (7,027)	$ 36,799	$ 43,873	$ (7,074)
Medicaid Managed Care	26,499	33,356	(6,857)	131,360	138,612	(7,252)
Medicare	4,244	5,325	(1,081)	15,285	18,143	(2,858)
Medicare Managed Care	6,598	8,072	(1,474)	22,512	24,231	(1,719)
Other	10,714	11,083	(369)	39,728	40,478	(750)
Total Outpatient	$ 54,526	$ 71,335	$ (16,809)	$ 245,684	$ 265,338	$ (19,654)
All Other						
Pools	$ 5,399	$ 4,245	$ 1,155	$ 118,413	$ 117,851	$ 562
DSH / UPL	201,100	201,100	0	201,100	201,100	0
Grants, Intracity, Tax Levy	10,035	15,176	(5,141)	311,169	310,512	657
Appeals & Settlements	4,084	-	4,084	128	(2,627)	2,755
Misc / Capital Reimb	5,813	3,146	2,666	21,643	14,529	7,113
Total All Other	$ 226,431	$ 223,667	$ 2,764	$ 652,453	$ 641,365	$ 11,088
Total Cash Receipts	**$ 472,997**	**$ 507,526**	**$ (34,529)**	**$ 1,560,029**	**$ 1,583,732**	**$ (23,703)**
Cash Disbursements						
PS	$ 209,439	$ 203,351	$ (6,088)	$ 713,232	$ 703,672	$ (9,560)
Fringe Benefits	72,565	72,544	(21)	229,485	228,195	(1,291)
OTPS	110,624	112,313	1,689	378,470	350,728	(27,742)
City Payments	-	-	0	309,405	309,405	0
Affiliation	85,021	82,478	(2,543)	268,468	265,503	(2,964)
HHC Bonds Debt	5,814	6,815	1,001	19,810	20,445	635
Total Cash Disbursements	**$ 483,463**	**$ 477,501**	**$ (5,963)**	**$ 1,918,870**	**$ 1,877,948**	**$ (40,922)**
Receipts over/(under) Disbursements	**$ (10,467)**	**$ 30,025**	**$ (40,492)**	**$ (358,841)**	**$ (294,216)**	**$ (64,625)**

NORTHERN MANHATTAN/GEN+ NETWORK BUDGET PLAN

Managing To The
HHC Global Expenditure Cap
Jan 1, 2015 – June 30, 2016

NYC
HEALTH+
HOSPITALS

PS Expense Categories Covered By the Global Expenditure Cap

- HHC Fulltime
- HHC Part-time
- HHC Per Diem
- All Temps
  - Nursing Temps
  - Allied Health Temps
  - Administrative Temps
- Overtime
- Other Supplemental Pay
- Affiliate

Global FTE Cap vs FY16 Actuals $$$

FACILITY	FY16 Target $ Sept YTD	FY16 Actual $ Sept YTD	FY16 Variance $ Sept YTD
HARL	$65.1m	$68.3m	$-3.2m
RENN	$3.6m	$3.8m	$-.2m
LINC	$85.0m	$87.9m	$-2.9m
BELV	$2.8m	$2.9m	$-.1m
MORR	$4.9m	$5.3m	$-.4m
Total	**$168.4m**	**$161.2m**	**$-6.8m**

Causes for Increase from FY 14 Baseline

- Plan of Corrections with TJC and CMS.
- Emergency Room Expansions
- PCMH Staffing
  - Extended hours (nights & Saturdays)
- Meeting contracted services FTEs
  - Sodexo
  - Crothall EVS
  - JCI
- Providing Limited English Proficiency Services
  - Interpreters

Opportunities to Manage the Cap

REVENUE ENHANCEMENT • **RIEs** • **PRODUCTIVITY INCREASES** • **CHARGE CAPTURE** • **OPERATIONAL EFFICIENCIES** • ***Rationale: As charge capture increases, the FTEs allowed increase***	**PS EXPENSE REDUCTION** • **MANGERIAL FTE REDUCTION** • **ABSENTEEISM REVIEW** • **OT REVIEW** • **TEMPORARY STAFF UTILIZATION** • **AFFILIATION STAFF** • ***Rationale: Reduce FTEs in non-revenue areas***
WORKLOAD INCREASES • **GROWTH** • ***Rationale: As workload and charges increase, the FTE allowed increases***	**SERVICES REVIEW** • ***Rationale: Consolidate across healthcare system and service improvement review and best practices***

PS Expense Reduction Opportunities

- Another line-by-line review of PS budget
- Optimization of nursing patient care hours (NASH)
- Sick time utilization review
- OT utilization review
- Review and Standardize OT authorization process
- Temporary agency expenses by cost center
- Managerial Review (consolidation of roles)
- Consolidation of similar job functions
- Analyzing current vacancies

Workload Increases

- Community Provider Referral Office Strategy
- Emergency Room Flow
- OPD Capacity Analysis
- Ambulatory Care Transformation
  - Access Metrics
- Growth Services
  - Surgery
  - Dental
  - Medicine
  - Maternal Child
- Rebasing with updated volume

Revenue Enhancement

Rebasing to reflect revenue enhancements:

- Coding Documentation Improvements (Case Mix Index)
- Ancillary Charge Capture
- Dental Charge Capture
- OPD Mental Health
- Radiology Services
- Chemo/Infusion/Cancer Center
- Pharmacy RXs charge capture
- Registration
- OPD Billing
- ED Billing
- Ambulatory Care Coding
- Interpreter Services Billing

Services Review

Review of Low Volume / High Cost Services

- Neurosurgery
- Rehab
- Orthopedics
- Interventional Radiology
- School of Radiology
- Grants with large in-kind
- Peri Operative – OR Utilization

Other Offsets Against Reductions

Gen Plus	FY16 YTD Actual	FY 16 YTD Budget	FY16 YTD Variance
OTPS	$91.9m	$97.4m	**$5.5m**
Inpatient Receipts	$115.5m	$109.0m	**$6.5m**
Outpatient Receipts	$45.3m	$44.5m	**$.8m**
Misc	$4.4m	$1.3m	**$3.1m**