AGENDA

FINANCE COMMITTEE

MEETING DATE: APRIL 3, 2012
TIME: 9:00 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER — **BERNARD ROSEN**

ADOPTION OF THE *MARCH 13, 2012* MINUTES

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

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS — **FRED COVINO**

INFORMATION ITEMS

1. **MEDICAID ELIGIBILITY REPORT –FEBRUARY 2012** — **MAXINE KATZ**

OLD BUSINESS
NEW BUSINESS
ADJOURNMENT — **BERNARD ROSEN**

MINUTES

MEETING DATE: MARCH 13, 2012

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on March 13, 2012 in the 5th floor Board Room with Bernard Rosen presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

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

OTHER ATTENDEES

M. Dolan, Assistant Director, DC 37
M. Dubowski, Analyst, City Office of Management & Budget (OMB)
C. Fiorentini, Analyst, Independent Budget Office (IBO)
S. Hill, Account Executive, Quadra Med
R. McIntyre, Account Executive, Siemens
M. Meagher, Analyst, OMB
J. Wessler, Commission on the Public Hospital System (CPHS)

HHC STAFF

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

Minutes of the March 13, 2012 Finance Committee Meeting

A. Cohen, Chief Financial Officer, South Manhattan Health Care Network
F. Covino, Corporate Budget Director, Corporate Budget
J. Cuda, Chief Financial Officer, MetroPlus Health Plan, Inc
L. Free, Senior Director, Managed Care
G. Guilford, Senior Director, Office of the Senior Vice President/Finance/Managed Care
D. Guzman, Associate Director
J. John, Chief Financial Officer, Central Brooklyn Health Network
L. Johnston, Senior Assistant Vice President, Medical & Professional Affairs
M. Katz, Senior Assistant Vice President, Corporate Revenue Management
V. Kim, Director, Corporate Planning/HIV Services
D. Koster, Director, Corporate Budget
P. Lockhart, Secretary to the Corporation, Office of the Chairman
N. Mar, Director, Corporate Reimbursement Services/Debt Financing
A. Marengo, Senior Vice President, Corporate Communications/Marketing
A. Martin, Executive Vice President/COO, Office of the President
H. Mason, Deputy Executive Director, Kings County Hospital
T. Mammo, Deputy Chief of Staff, Office of the President
R. Mayer, Director, Corporate Internal Audits
K. McGrath, Senior Director, Corporate Communications/Marketing
L. Migdal, Deputy Chief Financial Officer, Corporate Finance
D. Moskos, Director, Office of Facilities Development
M. Nunez, Chief Financial Officer, North Brooklyn Health Care Network
P. Pandolfini, Chief Financial Officer, Southern Brooklyn Health Care Network
G. Ranghelli, Chief Financial Officer, Coler/Goldwater Specialty Hospital and Nursing Facility
S. Russo, Senior Vice President, General Counsel, Office of Legal Affairs
A. Saul, Senior Associate Director, Kings County Hospital Center
W. Saunders, Assistant Vice President, Intergovernmental Relations
L. Simowitz, Associate Executive Director, Jacobi Medical Center
B. Stacey, Chief Financial Officer, Queens Health Network
L. Tulloch, Deputy CFO, Harlem Hospital Center
J. Wale, Senior Assistant Vice President, Behavioral Health Services
J. Weinman, Corporate Comptroller, Corporate Comptroller's Office
M. Williams, Assistant Vice President, Corporate Affirmative Action/EEO
M. Zurack, Senior Vice President, Corporate Finance/Managed Care

Minutes of the March 13, 2012 Finance Committee Meeting

CALL TO ORDER:

The meeting of the Finance Committee was called to order at 9:07 a.m. The minutes of the February 7, 2012 Finance Committee meeting were adopted as submitted.

CHAIR'S REPORT — BERNARD ROSEN

SENIOR VICE PRESIDENT'S REPORT — MARLENE ZURACK

Ms. Zurack informed the Committee that her report would include an update of two items, the status of HHC's cash flow and an overview of the recommendations that came out of the technical advisory group on indigent care. Currently, HHC's cash on hand is at 33 days, a slight increase from last month of 27 days. Although it is anticipated that the current cash on hand will increase by year-end, it is contingent upon the receipt of $673 million in UPL payments of which a portion of those funds has been approved by CMA for release to HHC. Overall, HHC's cash status is stable. Ms. Zurack moving to her next item stated that the MRT passed the findings reported by the subgroup on payment reform. However, one of the findings of the subgroup was that there needed to be another subgroup, the technical advisory group which concluded week ago and is expects to make changes in the current legislative session. As part of that group, Ms. Zurack represented the public hospitals. The health disparity workgroup had adopted its position on indigent care reform as part of its original subgroup meetings and the MRT passed the health disparity recommendations but acknowledged that the subgroup on payment reform team had the authority to opine on indigent care. In terms of the technical advisory group findings, there was an acknowledgement of two studies that came from the Independent Consumer groups, both of which contributed to the debate that led to the technical advisory group findings. Additionally, there was a study that was done by the Commission on the Public's Health System that hired Alan Sager who looked at the current indigent care formulas and attempted to correlate current formulas to actual provision of care to the uninsured. The findings were that the current formulas do not adequately reward hospitals for taking care of the uninsured and recommended changes in the formulas to be more reflective of care to the uninsured. The second study was recently released and has received a lot of press from the Community Service Society. That study which was similar to a desk audit based on information included in their reports that the State Department of Health (SDOH) had been collecting, detailed how well hospitals were complying with the financial assistance law (FAL) which was passed in 2006 requiring that hospitals provide charity care. Based on that study, and five years after the implementation of the FAL, many of the requirements were not being universally met. Additionally, a number of problems were cited in the study. Accordingly these were major agenda items on the technically advisory committee's task list. The group's representation included consumer groups, hospital chief financial officers (CFO) and trade associations. Another piece of background, recent changes in federal law, the Accountable Care Organization, (ACO) changes the way Disproportionate Share (DSH) will ultimately be cut when Secretary Sebelius, Health & Human Services (HHS) implements the cut federally in 2014, which will begin October 1, 2013. In the federal law, the Secretary of HHS must cut DSH, whereby there are annual DSH cuts that must be implemented. The Secretary will have a choice in the way in which that cut will be implemented, based on the change in the number of uninsured in a given State, or based on how well a State targets its uninsured funding. Good is defined in terms of targeting uninsured funding

as funding being targeted to high Medicaid and uninsured hospitals and targeting excluding bad debt in all of its calculations. Many of the hospital members of the trade associations initially started indigent care funding long before DSH funding was available. DSH funding is the federal matching funds that are being cut and originally those funds were a pool of surcharges that each hospital paid into and redistributed amongst them with no federal support. As part of that original creation, which is thirty years old, the funding was intended to support bad debt, and to help hospitals that were experiencing financial difficulties. However, over the years it changed after the federal DSH matching funds were provided. However, the major change came in 2006 when the FAL passed which not only established what it means to provide charity care to individuals but meeting the minimum standards of provision of charity care is a precondition to receiving indigent care or uncompensated care funding. The department acknowledged based on the information received from the Community Service Society that a number of hospitals are not in compliance with the FAL and that applications are not accessible to patients; the data that is being reported is not accurate and enforcement needs to be strengthened. The SDOH is scheduled to put forth administratively and maybe legislatively the following recommendations: requiring that when hospitals deem patients accounts to be charity care a notification is sent to those patients; the notification must include the SDOH telephone number; there needs to be annual education of hospital staff and consumers on the FAL. As part of that process, Ms. Katz has already been asked by GNYHA to provide education to the voluntary hospitals on how to provide fee scaling, a charity care to patients. Also there will be an enhancement of the requirement that hospitals post their charity care policies on their websites which will be linked to SDOH website; and chief financial officers (CFO) will be required to attest annually compliance with the FAL. The State has hired KPMG as an independent auditor and will be conducting audits on FAL. Ms. Zurack stated that she recommended that the current bad debt audit be discontinued given that it is duplicative and is currently under consideration by the State. There will be a recommendation to have judgments in addition to liens reported on the websites and consideration is being given to some type of penalty for non-compliance.

Ms. Cohen asked if the recommendation was from the group or whether it is an accepted work plan of SDOH.

Ms. Zurack stated that although there is very little difference in the two, it is the recommendation of the group. It appears that legislation is needed and is included in the recommendation. It is important to note that the SDOH was well represented and it may not all happen at once but it is the work plan. The second piece will require legislation that would be debated in this current session as part of the State budget that is due 3/31/12, is the elimination of bad debt from the indigent care calculation; using uninsured units of service similar to the current 10% but for 100% of the distribution so it would be based on the number of visits, ambulatory surgery and clinic visits and or inpatient stays for uninsured based on the Medicaid rate and CMI, etc. Ms. Zurack stated that she also recommended that a score is given to hospitals similar to managed care plans based on how well hospitals perform with financial assistance and that score would drive the targeting. If a facility scored high in its financial assistance compliance, the hospital would get a greater percentage of its uninsured need. The compliance scores would be posted on the websites. Additionally, there is a need to protect rural and sole community hospitals that are very reliant on that funding. Given the federal DSH rules, finding, a different mechanism is needed to help those hospitals so that they are not viewed by the

federal government as NYS failing hospitals to be targeted. There is an option to provide transitional funding for those hospitals that will have the greatest losses in their revenue which would be a three year proposal. In terms of the urgency of this funding issue, NYS receives a large amount of DSH relative to the rest of the country, receiving 14% of the national DSH and has 8% of the uninsured. On the federal side, NYS received $1.6 billion compared to some other states that receive very little funding. Having a formula that is not compliant would not be supported and would therefore require legislation to implement. Additionally, it's important to note that in some instances, one hospital losing funding could stop the entire bill. The group and the trade associations fully understand the vulnerability of NYS and the importance of retaining the DSH funding for NYS.

Mr. Aviles asked how much of the federal DSH that is now allocated is based on bad debt as opposed to servicing the uninsured.

Ms. Zurack stated that the information was not readily available but that perhaps it could be addressed in a different way. NAPH engaged a consultant to conduct a review of targeted and non-targeted hospitals that were ranked by states. In one of their measures, if there is a cut off for DSH for only the Medicaid high end insured hospitals, would it apply to disproportionate share hospitals. NYS provides DSH funding to almost all hospitals in NYS which is problematic. In some ways NYS is fairly targeted due to the public hospitals but is it targeted because every hospital is getting a share and not knowing how the Secretary of HHS will define that metric would severely hurt NYS. NAPH's report showing the rankings would be shared with the Committee.

Mr. Aviles asked if the definition of charity care services to the uninsured included services to the uninsured patients where a particular service is not covered by that individual's insurance or that bad debt is being considered as uncompensated care.

Ms. Zurack stated that it would be counted as a unit if it is a whole unit. The co-insurance and deductible would not be counted. After netting out the revenue that the hospital would be getting, it would be the unit of service times the Medicaid rate amount less revenue collected from patients. There are a few hospitals in NYS that make a profit on their self-pay population who are mostly wealthy and refuse to buy insurance and pay at full charges. In that instance, that hospital would be required to deduct that revenue from what is allowable to claim.

Dr. Stocker asked what it would mean for HHC if the recommendations were passed by the Legislature.

Ms. Zurack stated that currently there are two separate pools, voluntary and public. The new formula will be used within each pool but the firewall between the two pools will remain. For example, HHC would get approximately $95 million from the public pool that is $139 million; therefore, HHC would get more of the public pool. In terms of the voluntary sector there is a significant redistribution. If a fair system is available, HHC would need to compensate for other hospitals failure to meet the FAL requirements. The public hospitals do get most of the DSH through the Intergovernmental Transfer (IGT) payment and insofar as the State is protected from cuts, the DSH that is used for the IGT payment would be protected as well.

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Dr. Stocker asked if there is a way to quantify the impact to HHC. Ms. Zurack stated that at this time it is difficult to quantify the impact; however, at some point the SDOH will be issuing reports reflecting that data in order to get the legislation passed.

Ms. Zurack asked Wendy Saunders, Assistant Vice President (AV) and John Jurenko, Senior AVP, Intergovernmental Relations and HHC's representatives at the State level to come forward given the timing of the legislative piece, they would be in a better position to address Dr. Stocker's question.

Ms. Saunders stated that the Legislature is on track at this point to pass not just on time but an early budget. Over the weekend both houses released their individual one house budget bills. The Assembly finished passing their proposals yesterday and the Senate is set to do the same today. The budget conference committees would also begin today. The plan is to conduct the budget conference committee process this week into next week and pass the budget bills that next week as well.

Mr. Aviles asked if pension reform could still be a major factor.

Ms. Saunders stated that it would appear that it will go forward and that a press conference is scheduled for today by the labor leaders in the State to discuss the deal that was reported to have been reached on pension reform.

Ms. Zurack asked if the SDOH put language in on this issue. Ms. Saunders stated that they have not but both houses of the legislature seem to be aware that it will be forthcoming.

Dr. Stocker asked if the proposed pension reform is being called Tier 6. Ms. Saunders stated that it is.

Mr. Rosen asked if the pension reform will be reflected in the Governor's budget.

Ms. Saunders stated that it would appear that based on reports from yesterday some type of agreement has been reached and it will be included in the final budget. The reports on some of the political blogs have discussed this and the Governor has stated that the budget would not be done without it being included. There has been some discussion that the agreement on the pensions will be linked to the agreement on the legislative reapportionment.

Mr. Jurenko added that it is important to note that the Governor controls the language of the bill; therefore, as the Governor has stated that it has to be in or the budget will not pass without it. If March 31, 2012 comes and there's no budget, the Governor would put it in an extender and the Legislature would be forced to shut down the State if that language is not included.

Mr. Aviles asked what the deadline is for Secretary Sebelius to announce what will happen with the distribution.

Ms. Zurack stated that in order to meet the October 1, 2013 deadline, there has to be regulations. Therefore, the speculation is that by the fall of 2012 there will be a preliminary plan of what will be done and by April 2013 a draft would be expected.

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Ms. Cohen following up on a previous question raised by Dr. Stocker regarding whether the impact of the distribution was quantifiable for HHC asked if there is any certainty of the impact to HHC.

Ms. Zurack stated that if it gets into the Legislation there will be an impact that the SDOH will release in a few weeks. Given that the data is not available for the other hospitals, it is difficult to speculate on the outcome for HHC. Moreover, it is not know at this time how many units of services there are for other hospitals; therefore, it is difficult to make that determination without actually doing the appropriate comparison of HHC to other hospitals. One estimate could be that it could go from a negative $10 million to a positive $10 million.

Ms. Cohen stated that even if this policy in isolation is net positive for HHC, there are other ways that the State could even out the impact using other methods for the other hospitals that will be impacted the most.

Ms. Zurack stated that the State has discussed including transition funding specific to this language from the pools and that she had suggested that the State uses other state funds but there has not been language forthcoming to address that recommendation which is key to pinpointing the impact. Notwithstanding, the State must resolve the problem of hospitals that will lose significant revenues and the individual providers who will lose substantial revenues. For some rural hospitals, a $20,000 reduction in funding could be unacceptable for the State; therefore, there would be a need to make those hospitals whole.

Ms. Brown, Senior Vice President, Corporate Planning/HIV Services, Intergovernmental Relations, & Community Health stated that while in Albany meeting with the Assembly and Senate staff, the question that was asked is what will happen to those hospitals that will lose significant funds. Politically, there has to be a solution and politically unless there is a solution on the transitional funding there will be no movement on this issue, notwithstanding, the importance of there being conformity with the Affordable Care Act (ACA). There are legislators who are willing to take a defiant stance before moving forward on anything unless their rural hospitals or their safety net hospitals in the city, suburban, etc are addressed and that there is transitional funding. Their concerns are that their hospitals are allowed to make a one-two year transition in the process without severely impacting their hospitals financially.

Ms. Saunders stated that there is a possibility for this in the Senate's budget proposal where legislation is included that will include the critical access hospitals which are the way those rural hospitals are being defined and would be paid at the Medicare rates. There was legislation that was passed by both houses last year but was vetoed by the Governor but is included in the Senate's budget proposal that could potentially be a mechanism to address that issue.

Ms. Zurack stated that in the budget there was funding for vital access providers (VAP) and many of those hospitals for a number of reasons could be considered VAP which could be another alternative to addressing that issue.

Ms. Brown stated that the Medicaid to Medicare payment is for outpatient. It is a critical issue for everyone even though it is understood that the big issue is that NYS is disproportionately affected by the reduction in DSH funding due to the lack of targeting in terms of the deployment of the DSH funds. Dr. Stocker asked if the downstate voluntary hospitals are in favor of that legislation. Ms. Brown stated that those hospitals would not be in favor of losing funding; however, those hospitals have been appropriately corralled by the trade associations, GNYHA and HANYS as well as the hospitals in the regions that they must accept the change in terms of creating a method to conform to the federal requirements. However, those hospitals are pushing for the transitional funding but realizing that they do not want the State to lose more than what is already programmed into the ACA.

Dr. Stocker commented that the vulnerability that the hospitals are facing is at the federal level. Ms. Brown agreed.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS FRED COVINO

Mr. Covino reported that the Key Indicators Report as of January 2012 shows that acute discharges are down by 5% which has remained at that level for the last couple of months. There is a slight trend of improvement in the Diagnostic and Treatment Centers which is down by 5% from last year. However, there is an improvement from 11% earlier in the year. Nursing home days have remained down by 5%. The ALOS, all of the facilities are within 1/3 day of the corporate average with the exception of Coney Island and Lincoln, 4/10 and ½ day respectively. The case mix index (CMI) is up by .5% compared to last year based on an improvement of 10.5% over the last 2-year period.

Dr. Stocker asked how many years has there been an increase in the CMI.

Mr. Covino stated that for the last two years there has been an increase. Continuing with the reporting, FTEs are down by 178 which are 235 below the target. Receipts are $3.9 million better than budget while disbursements are $36.8 million better resulting in a net positive surplus year-to-date (YTD) of $40.7 million. Cash receipts and disbursements actuals, receipts are $392 million worse than last year due to the timing of DSH and UPL payments. Expenses are $80.3 million worse than last year due to the timing of City payments which are up by $67 million YTD. Overall, receipts and disbursements are $472 million worse than last year for the same period. A comparison of actual to budget, inpatient receipts are up by $8.2 million due to an increase in Medicare fee for service of $31 million. Outpatient receipts are up by $9.6 million due to Medicaid managed care, whereby a retroactive rate increase for the emergency room and ambulatory surg of $26 million was received last month. All other receipts are down by $14 million due to a 2009 retro rate take back in the appeals and settlements category. PS expenses are $2.2 million over budget due to overtime. There is a $4.6 million surplus in fringe benefits due to the timing of health and welfare fund payments. There is a $35 million OTPS surplus due to the rollover from last year into this year and a surplus in IT due to the timing of projects.

INFORMATION ITEM FRED COVINO
PERSONAL SERVICES KEY INDICATORS QUARTERLY REVIEW 6/18/11 – 1/14/12

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Mr. Covino stated that before beginning the report, it is important to put into context the impact of the reduction in FTEs on the various expense categories. FTEs are down by 576 which on an annualized basis represent PS and fringe benefit saving of $50 million. A comparison of the current FTEs to FY 2009, FTEs are down by 2,500 which on an annualized basis represent $218 million in savings. Therefore, it is important to recognize those savings in comparison to the current trends in nurse registry, overtime and allowances. A comparison of PS disbursements against the budget showed $2.2 million over budget due to overtime as reflected in the report. FTE reduction by facility, Mr. Covino pointed out that the Enterprise IT was established this year and is therefore a new entity, whereby all of the staff from the facilities was transferred to a central office cost center. Page 4, FTE reduction by category, the reduction is primarily in environmental services, aides and orderlies. Page 5, a comparison of overtime actual versus the budget, to-date expenses are up by $4.9 million compared to last year of which $2.5 million is due to expenses incurred for the hurricane that occurred earlier in the year. There is $1 million in nursing overtime, $700,000 for primary care techs and associates and $300,000 for hospital security officer.

Dr. Stocker asked if the positive variance in techs/specs is related to the replacement of consultants.

Mr. Covino stated that it is and that some of those positions were consultants in IT, the remainder of that increase is related to an increase in HCIs of 33 FTEs. A comparison of overtime to the prior year which is $4 million YTD, of which $1 million was in nursing, plant maintenance $.5 million and all other $2.5 million. The increase is primarily in patient care techs/associates and special officers. Nurse registry is up by $4 million due to the timing of the replacement of staff and training at Lincoln in the ER for new nurses. The registry is being used to cover those staffing shortfalls. Allowances are down by $1 million compared to last year.

INFORMATION ITEM **FRED COVINO**
OPERATING FINANCIAL PLAN

Mr. Covino stated that the financial plan is a part of the City's overall budget process and for compliance with the State Public Authority Accountability Act (PAAA). The plan includes the actual results from FY 11, the budget for the current FY 12 and the Corporation's plan for FY 13-16. The plan is comprised of three sections, receipts on the first page followed by disbursements and the corrective actions on the second page. The Medicaid fee for service revenues are forecasted based on the current YTD actual and adjusted for items that have not been reflected in the receipts such as retro rate adjustments and prior year appeals and settlements. The plan reflects a 4% reduction in workload based on the current utilization trends as reported which translates to a $65 million annual reduction to the baseline. In accordance with the MRT, the plan assumes a 2% reduction which will be restored in the last quarter of FY 2013. Additionally, the plan includes a 2% trend increase from FY 2014. The UPL shows a decline in FY 12 compared to FY 11 due to a reduction in receipts on behalf of the prior years. In FY 11, $943 million was received for prior year UPL payments and in the current FY 12 of $409 million. In FY 12, it is anticipated that the prior year balance will be received that will result in a stable baseline going forward. There are two components of the DSH payment, the base DSH of $330 million and the DSH maximization which varies over the term of the plan. Projected DSH max payments range from $305 million in FY 11 to $387 million in FY 12. The change is based on the State DSH cap. In FY 14,

the federal health reform will reduce the DSH payments by 5% per year. The DSH reduction also affects the pools in the out years as the BDCC pools are funded through the DSH.

Ms Cohen added that the pools are DSH but different formulas.

Mr. Covino continuing with the reporting stated that Medicaid managed care is projected to increase but the rate of growth is expected to decline resulting in a reduction of the growth from 5% per year to 3% annually. Medicaid managed care also includes enhancements of approximately $100 million per year. It also includes the MetroPlus risk pool payments which are averaged at $50 million per year.

Ms. Cohen asked if the assumption is that the growth in managed care will decline even though a number of individuals will be transferred from fee-for service into some form of managed care.

Mr. Covino stated that there has been a decline over the years. At one point it was as high as 20% and has slowly declined and the current projected trend is consistent with MetroPlus forecast in terms of their membership enrollment.

Mr. Aviles commented that in FY 16 a 5% straight-line reduction is reflected in DSH; even though it is projected that the DSH cut will become deeper in FY 16.

Ms. Zurack stated that it is in FY 17 for HHC, the federal FY is different.

Mr. Covino continuing with the reporting stated that in FY 17 it will be reduced and FY 21 there is a larger reduction. Medicare receipts are projected to be reduced in accordance with the federal health care reform in addition to a 2% reduction from the debt ceiling cuts which is 5% beginning in FY 14. Medicare managed care also reflects the same reductions. Managed care other includes HMOs and CHP which in total it is forecasted to remain flat. Year over year there are considerable fluctuations in those dollar amounts. City service in FY 12 payments are greater than the out-years due to City Council restorations of $13 million for child health clinic, HIV Rapid funding; and mental retardation and developmental disabilities (MRDD) clinics and the FY restoration of the PEG program which will begin in FY 13. The City Council restorations are done annually; therefore, projected funding for the out-years is not reflected. Grants are projected to remain flat with minor variances due to anticipated timing of Medicaid administration. Expenses do not include projected savings related to the restructuring projects. The plan will be updated in the Executive Plan in the coming weeks. PS expenses are projected to remain flat with a 1.25% increase per year beginning in FY 15. Fringe benefits are projected to increase by 3% to 6%; however, the plan does not include the anticipated increase in pension of approximately 10%. When the plan was developed, the data was not yet finalized to allow for its inclusion. Overall, health insurance premiums are projected to increase by 8.6% per year or 40% over the life of the plan while pension increases are projected to increase by 3% to 10% before the 10% add-on for 23% over the life of the plan. OTPS expenses are projected to increase by 3% beginning in FY 13 and each year thereafter. Malpractice expenses in FY 12 include two payments, a prior year and the current year. In FY 13 the payments are projected to decrease to $135 million which is the baseline and reflective of the MRT's savings that are anticipated as a result of malpractice reform. Affiliation expenses are projected to increase by 3% per year and debt service

projected average of $242 million per year of which 60% is City and 40% is HHC. The below the line actions include the anticipated receipts, disbursements, losses that are approaching $1.2 billion by the last year of the plan. The corrective action plan includes the remainder of the cost containment and saving initiatives of $25 million to $30 million per year and restructuring savings as previously mentioned. Although these savings are below the line to-date a significant portion has been achieved which will be moved above the line in FY 12 after the completion of the analysis in the Executive budget. In addition there are significant savings for State and federal actions scheduled to begin in FY 13 of $215 million growing to $850 million by the end of the plan, FY 16.

Mr. Aviles stated that it is important to note that those savings for the State and Federal are yet to be determined.

Ms. Zurack stated that while HHC has some plans that will yield some savings in State and Federal actions, if not achieved, HHC will need to substitute more cost containment initiatives which will be further discussed with Mr. Aviles on how and when those actions will be taken for next year.

Ms. Cohen asked for clarification of HHC savings initiative cost containment versus restructuring.

Mr. Covino stated that it is primarily revenue enhancements

Ms. Zurack stated that from a mechanical perspective, the first line was done in 2009 and second was last year.

Mr. Rosen stated that the incorporation of the State and Federal actions is essential to the overall plan.

INFORMATION ITEM **MAXINE KATZ**
MEDICAID ELIGIBILITY REPORT

Ms. Zurack informed the Committee that the Eligibility Report would be given by Mr. Frank Donno, Senior Director, Revenue Management due to Ms. Katz's laryngitis.

Mr. Donno stated that this year through January 2012, eligibility compared to submissions represents about 88.5% compared to last year's 85.8%. A number of the facilities are over 90% in terms of their eligible rate compared to last year for the same period. There were only two facilities that were over their target last year compared to four facilities this year that are over 90% of their eligibility target.

Dr. Stocker stated that some of the facilities such as Bellevue are down, whereas Kings County is up.

Ms. Zurack stated that it is important to put into context what the information that is being reported represents in terms of improvements. To that point, last week a Rapid Improvement Event (RIE) was held at Bellevue and based on that event it is anticipated that Bellevue will show improvement in the months ahead.

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Dr. Stocker asked how soon after the RIEs are completed the progress improvement will begin to show in the numbers.

Mr. Donno stated that the two models have been running at Lincoln and Elmhurst since early January 2012 and it is expected that by the end of March 2012 a decision will be made as to which of the models will be implemented based on the level of improvement. Preliminarily, the models are very close in terms of their benefits. Therefore, there may be two models going forward. There is a final event scheduled for April 23, 2012 to focus on physician documentation, Form 4471, emergency Medicaid certification and Form 486 for disability certification.

Dr. Stocker asked what the expected time frame is for choosing the improvement model.

Mr. Donno stated that a number of the facilities have either viewed or used both models and some have begun implementing portion of the models. For example, Kings County has shown significant improvement by making use of both models that has resulted in an improvement in their process flow in terms of the rotation of staff assigned to retrieving applications from the emergency department as well as covering the multiple pick-ups throughout the day.

Dr. Stocker added that from month to month there is a slight improvement.

Ms. Zurack asked Mr. Donno what the lag time is for application submissions.

Mr. Donno stated that it is from a month to a year; however, based on a review of the submissions as part of the model, the application submission time frames are shortening.

Ms. Zurack stated that it would not be reflected in the monthly reporting given that the report is reflective of the decisions on the activity that took place months ago as far back as September 2011. Therefore, the big improvements are around that time period. The report is lagging improvements by 3-4 months. For example, at an RIE report-out at Bellevue, it was noted that the facility had already implemented a number of the improvements during that week and their plan is scheduled for completion by May 31, 2012. Therefore, the impact of those changes would not be reflected in the data until September 2012.

INFORMATION ITEM **JAY WEINMAN**
STATEMENT OF REVENUES & EXPENSES AS OF 12/31/11 TO 12/31/10

Mr. Weinman stated that the report covered the second quarter of the current FY 12 through December 31, 2011. Overall, the Corporation's loss through that period is $482 million compared to $197 million last year for the same period. Operating revenues, net patient revenues decreased by $252 million due to four items, $54 million decrease in supplemental Medicaid managed care for MetroPlus; $44 million additional revenue for the HMO for one GME case mix adjustment; $15 million reduction for the 2% Governor's proposed cut effective 4/1/2011. Appropriations increased by $5 million but remains negative which means the payments made to the City exceeded what HHC received from the City for services, a slight improvement over the last year. Premium revenue

increased by $231 million or 37% due to $114 million for the pharmacy carve out effective 10/1 which is MetroPlus revenues for pharmacy costs; $42 million IGT and $50 million premium rate increased retroactive to 4/1 and $26 million for enrollment growth. Operating expenses, PS expenses decreased by $15 million which is reflective of the 640 FTEs reduction last year of 24%. Other Than Personal Services (OTPS) expenses increased by $157 million primarily due to the increase in MetroPlus of $114 million for pharmacy and rate increases/membership growth. After deducting those items from the OTPS expenses, expenses decreased by 1.4%. Fringe benefits and employees payroll taxes increased by $33 million or 6.8% health insurance increased by 10%; pension by 19.5% and post employment benefits increased by $65 million, accruing annually at $700 million for the year up from the $620 million reported at the end of last year due to anticipated increases, interest rates and the increases over the past years. Affiliation expenses increased by $19 million or 4.7% slightly down from the increase last quarter but relatively consistent from period to period.

Ms. Zurack stated that a large portion of the non-cash expenses are driving the size of the deficit and that if those items were excluded, it would be significantly different not to diminish the impact of the post employment benefit which is becoming very large.

Mr. Rosen stated that it is huge for the City as well. The numbers are becoming astronomical.

Ms. Zurack stated that the rating agencies and actuaries have discussed this as being a national problem; however, it does address the issue of health insurance for retirees and the impact of that as an expense.

Mr. Weinman added that the $700 million accrued annually less than $100 million is actually cash pay-go.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 10:03 a.m.

KEY INDICATORS

FISCAL YEAR 2012 UTILIZATION

Year to Date
February 2012

NETWORKS	UTILIZATION			AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	FY 12	FY 11	VAR %	ACTUAL	EXPECTED	FY 12	FY 11
North Bronx							
Jacobi	13,409	13,547	-1.0%	5.9	6.0	1.1130	1.1130
North Central Bronx	5,401	5,381	0.4%	4.4	4.3	0.7268	0.7404
Generations +							
Harlem	7,038	7,997	-12.0%	5.4	5.6	1.0234	0.9620
Lincoln	15,581	16,947	-8.1%	4.8	5.2	0.9436	0.9473
Belvis DTC	43,791	46,343	-5.5%				
Morrisania DTC	65,515	54,759	19.6%				
Renaissance	44,659	48,991	-8.8%				
South Manhattan							
Bellevue	16,626	16,566	0.4%	6.1	6.0	1.1423	1.1701
Metropolitan	7,770	7,852	-1.0%	4.5	4.8	0.7954	0.8705
Coler	198,457	226,974	-12.6%				
Goldwater	211,657	214,371	-1.3%				
Gouverneur - NF	45,604	48,940	-6.8%				
Gouverneur - DTC	183,803	206,675	-11.1%				
North Central Brooklyn							
Kings County	15,939	15,397	3.5%	5.8	5.8	1.0637	1.1069
Woodhull	9,477	10,572	-10.4%	4.9	4.7	0.8349	0.8614
McKinney	76,700	75,604	1.4%				
Cumberland DTC	64,315	71,206	-9.7%				
East New York	56,123	56,685	-1.0%				
Southern Brooklyn / S I							
Coney Island	11,067	11,727	-5.6%	6.3	5.9	1.1138	1.1067
Seaview	72,693	72,462	0.3%				
Queens							
Elmhurst	16,514	17,228	-4.1%	5.2	5.1	0.9583	0.9236
Queens	8,644	10,539	-18.0%	5.1	5.0	0.9205	0.8309
Discharges/CMI-- All Acutes	127,466	133,753	-4.7%			0.9946	0.9924
Visits-- All D&TCs	458,206	484,659	-5.5%				
Days-- All SNFs	605,111	638,351	-5.2%				

Notes:

Utilization

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

Average Length of Stay

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

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

All Payor CMI

All acute discharges are grouped using the 2011 New York State APR-DRGs

KEY INDICATORS

FISCAL YEAR 2012 BUDGET PERFORMANCE ($s in 000s)

Year to Date
February 2012

NETWORKS	FTE's VS 6/18/11	RECEIPTS actual	RECEIPTS better / (worse)	DISBURSEMENTS actual	DISBURSEMENTS better / (worse)	BUDGET VARIANCE better / (worse)	
North Bronx							
Jacobi	(96.0)	$ 285,567	$ 2,217	$ 360,764	$ 12,670	$ 14,887	2.3%
North Central Bronx	(10.0)	106,390	10,770	117,074	6,621	17,390	7.9%
	(106.0)	$ 391,957	$ 12,987	$ 477,837	$ 19,290	$ 32,278	3.7%
Generations +							
Harlem	(30.0)	$ 174,303	$ (3,936)	$ 230,014	$ (13,357)	$ (17,293)	-4.4%
Lincoln	2.0	272,124	11,765	322,660	7,963	19,727	3.3%
Belvis DTC	1.0	7,298	598	9,128	1,869	2,467	13.9%
Morrisania DTC	(1.0)	12,680	1,967	16,386	4,097	6,063	19.4%
Renaissance	1.0	8,894	1,387	14,038	1,080	2,466	10.9%
	(27.0)	$ 475,299	$ 11,780	$ 592,225	$ 1,651	$ 13,431	1.3%
South Manhattan							
Bellevue	(28.0)	$ 412,494	$ 6,274	$ 472,681	$ (2,731)	$ 3,543	0.4%
Metropolitan	(52.0)	159,465	(13,538)	204,982	5,331	(8,207)	-2.1%
Coler	(24.5)	68,131	(3,916)	89,254	(11,432)	(15,348)	-10.2%
Goldwater	(26.5)	84,757	(14,517)	115,010	(10,409)	(24,926)	-12.2%
Gouverneur	(15.0)	58,013	(753)	61,358	4,745	3,993	3.2%
	(146.0)	$ 782,861	$ (26,450)	$ 943,286	$ (14,496)	$ (40,946)	-2.4%
North Central Brooklyn							
Kings County	(92.5)	$ 408,699	$ 26,469	$ 461,272	$ 3,649	$ 30,118	3.6%
Woodhull	(80.0)	$ 198,359	$ (23,900)	$ 265,521	$ 455	$ (23,445)	-4.8%
McKinney	(12.0)	29,292	(848)	29,798	(611)	(1,459)	-2.5%
Cumberland DTC	(5.5)	14,032	(626)	21,837	(3,940)	(4,566)	-14.0%
East New York	(3.0)	12,227	332	14,452	1,049	1,381	5.0%
	(193.0)	$ 662,610	$ 1,426	$ 792,880	$ 603	$ 2,030	0.1%
Southern Brooklyn/SI							
Coney Island	39.0	$ 200,700	$ 19,082	$ 235,758	$ 4,968	$ 24,050	5.7%
Seaview	(15.0)	27,313	(283)	32,600	(257)	(540)	-0.9%
	24.0	$ 228,013	$ 18,800	$ 268,358	$ 4,711	$ 23,510	4.9%
Queens							
Elmhurst	(37.5)	$ 313,024	$ 2,305	$ 354,436	$ 22,161	$ 24,466	3.6%
Queens	(26.5)	190,114	12,128	234,943	(14,281)	(2,153)	-0.5%
	(64.0)	$ 503,138	$ 14,433	$ 589,379	$ 7,880	$ 22,313	2.1%
NETWORKS TOTAL	**(512.0)**	**$ 3,043,878**	**$ 32,976**	**$ 3,663,964**	**$ 19,639**	**$ 52,616**	**0.8%**
Central Office	(243.5)	475,062	(928)	158,556	11,518	10,591	1.6%
HHC Health & Home Care	10.0	12,870	(6,123)	24,592	98	(6,025)	-13.8%
Enterprise IT	542.0	0	0	105,290	6,944	6,944	6.2%
GRAND TOTAL	**(203.5)**	**$ 3,531,810**	**$ 25,926**	**$ 3,952,402**	**$ 38,200**	**$ 64,125**	**0.9%**

Notes:

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

New York City Health & Hospitals Corporation
Cash Receipts and Disbursements (CRD)
Fiscal Year 2012 vs Fiscal Year 2011 (in 000's)
TOTAL CORPORATION

	Month of February 2012			Fiscal Year To Date February 2012		
	actual 2012	actual 2011	better / (worse)	actual 2012	actual 2011	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 83,801	$ 101,292	$ (17,491)	$ 726,351	$ 774,523	$ (48,172)
Medicaid Managed Care	48,090	42,904	5,186	382,789	395,882	(13,093)
Medicare	61,604	42,353	19,251	391,597	336,246	55,352
Medicare Managed Care	18,929	21,095	(2,166)	163,290	160,726	2,564
Other	18,269	19,616	(1,347)	153,402	146,462	6,939
Total Inpatient	$ 230,693	$ 227,261	$ 3,432	$ 1,817,429	$ 1,813,839	$ 3,590
Outpatient						
Medicaid Fee for Service	$ 16,211	$ 18,946	$ (2,735)	$ 132,770	$ 162,980	$ (30,210)
Medicaid Managed Care	27,389	21,112	6,277	240,159	224,259	15,900
Medicare	6,536	5,250	1,287	45,433	43,512	1,921
Medicare Managed Care	4,963	4,713	250	64,327	53,083	11,244
Other	11,445	9,740	1,705	100,145	95,111	5,035
Total Outpatient	$ 66,544	$ 59,760	$ 6,784	$ 582,833	$ 578,944	$ 3,889
All Other						
Pools	$ 6,030	$ 13,876	$ (7,846)	$ 230,916	$ 233,807	$ (2,891)
DSH / UPL	-	-	-	715,650	1,107,686	(392,036)
Grants, Intracity, Tax Levy	11,007	23,594	(12,587)	156,416	160,912	(4,496)
Appeals & Settlements	(15,173)	30,649	(45,822)	(6,683)	45,873	(52,556)
Misc / Capital Reimb	3,871	3,783	88	35,248	38,161	(2,914)
Total All Other	$ 5,735	$ 71,902	$ (66,167)	$ 1,131,547	$ 1,586,440	$ (454,893)
Total Cash Receipts	**$ 302,972**	**$ 358,923**	**$ (55,951)**	**$ 3,531,810**	**$ 3,979,223**	**$ (447,413)**
Cash Disbursements						
PS	$ 187,789	$ 189,462	$ 1,673	$ 1,597,615	$ 1,626,115	$ 28,500
Fringe Benefits	59,996	67,659	7,663	656,841	660,582	3,741
OTPS	98,754	96,914	(1,840)	818,593	798,677	(19,916)
City Payments	-	-	-	235,784	168,852	(66,932)
Affiliation	71,683	67,681	(4,002)	581,592	558,599	(22,993)
HHC Bonds Debt	7,928	7,970	42	61,978	62,772	794
Total Cash Disbursements	**$ 426,150**	**$ 429,686**	**$ 3,536**	**$ 3,952,402**	**$ 3,875,596**	**$ (76,806)**
Receipts over/(under) Disbursements	**$ (123,178)**	**$ (70,763)**	**$ (52,415)**	**$ (420,593)**	**$ 103,626**	**$ (524,219)**

New York City Health & Hospitals Corporation
Actual vs. Budget Report
Fiscal Year 2012 (in 000's)
TOTAL CORPORATION

	Month of February 2012			Fiscal Year To Date February 2012		
	actual 2012	budget 2012	better / (worse)	actual 2012	budget 2012	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 83,801	$ 89,330	$ (5,529)	$ 726,351	$ 740,030	$ (13,678)
Medicaid Managed Care	48,090	46,968	1,123	382,789	402,634	(19,846)
Medicare	61,604	56,295	5,309	391,597	355,327	36,270
Medicare Managed Care	18,929	18,970	(41)	163,290	162,745	545
Other	18,269	17,068	1,201	153,402	146,424	6,977
Total Inpatient	$ 230,693	$ 228,632	$ 2,061	$ 1,817,429	$ 1,807,161	$ 10,268
Outpatient						
Medicaid Fee for Service	$ 16,211	$ 17,910	$ (1,699)	$ 132,770	$ 152,156	$ (19,387)
Medicaid Managed Care	27,389	24,234	3,154	240,159	215,484	24,675
Medicare	6,536	6,469	68	45,433	46,980	(1,548)
Medicare Managed Care	4,963	5,164	(201)	64,327	65,309	(983)
Other	11,445	10,567	878	100,145	91,118	9,028
Total Outpatient	$ 66,544	$ 64,345	$ 2,200	$ 582,833	$ 571,048	$ 11,786
All Other						
Pools	$ 6,030	$ 6,764	$ (734)	$ 230,916	$ 232,287	$ (1,371)
DSH / UPL	-	-	0	715,650	715,650	0
Grants, Intracity, Tax Levy	11,007	6,226	4,781	156,416	149,690	6,726
Appeals & Settlements	(15,173)	(29,271)	14,098	(6,683)	(6,671)	(12)
Misc / Capital Reimb	3,871	4,226	(356)	35,248	36,719	(1,472)
Total All Other	$ 5,735	$ (12,055)	$ 17,790	$ 1,131,547	$ 1,127,675	$ 3,872
Total Cash Receipts	**$ 302,972**	**$ 280,921**	**$ 22,051**	**$ 3,531,810**	**$ 3,505,884**	**$ 25,926**
Cash Disbursements						
PS	$ 187,789	$ 186,359	$ (1,430)	$ 1,597,615	$ 1,593,985	$ (3,630)
Fringe Benefits	59,996	59,367	(629)	656,841	660,882	4,042
OTPS	98,754	101,922	3,168	818,593	857,020	38,427
City Payments	-	-	-	235,784	234,651	(1,133)
Affiliation	71,683	71,957	274	581,592	580,359	(1,233)
HHC Bonds Debt	7,928	7,963	35	61,978	63,704	1,726
Total Cash Disbursements	**$ 426,150**	**$ 427,568**	**$ 1,418**	**$ 3,952,402**	**$ 3,990,602**	**$ 38,200**
Receipts over/(under) Disbursements	**$ (123,178)**	**$ (146,647)**	**$ 23,469**	**$ (420,593)**	**$ (484,718)**	**$ 64,125**

New York City Health and Hospitals Corporation
Monthly Medicaid Inpatient Processing Report
FY'2012-2011

	Fiscal Year To Date As of February 2012					
FACILITY	Medicaid Applications Submitted	Medicaid Eligible Decisions*	Ineligible Decisions	Addt'l Info Requested	PCAP Applications Submitted	Perinatal Care Assistance Program (PCAP) Eligible
BELLEVUE	3,505	2,795	397	276	461	413
CONEY ISLAND	1,724	1,470	72	68	488	469
ELMHURST	3,294	3,155	78	47	1,822	1,740
HARLEM	1,015	880	44	66	304	320
JACOBI	2,019	1,753	251	46	647	615
KINGS	3,190	2,948	121	105	1,157	1,159
LINCOLN	1,997	1,841	68	119	909	828
METROPOLITAN	1,425	1,172	74	68	644	652
NCB	919	892	42	32	683	655
QUEENS	1,704	1,511	95	91	701	726
WOODHULL	1,525	1,335	53	74	770	739
TOTAL	**22,317**	**19,752**	**1,295**	**992**	**8,586**	**8,316**

	Fiscal Year To Date As of February 2011					
FACILITY	Medicaid Applications Submitted	Medicaid Eligible Decisions*	Ineligible Decisions	Addt'l Info Requested	PCAP Applications Submitted	Perinatal Care Assistance Program (PCAP) Eligible
BELLEVUE	3,755	3,234	248	259	627	521
CONEY ISLAND	1,754	1,383	115	166	549	503
ELMHURST	2,981	2,551	78	54	1,963	1,903
HARLEM	1,077	911	61	106	401	382
JACOBI	1,956	1,623	135	156	862	823
KINGS	2,898	2,594	167	202	1,322	1,200
LINCOLN	2,216	2,046	28	93	871	827
METROPOLITAN	1,651	1,294	167	132	649	609
NCB	898	771	41	37	642	650
QUEENS	1,980	1,631	57	151	940	864
WOODHULL	1,663	1,551	63	87	761	732
TOTAL	**22,829**	**19,589**	**1,160**	**1,443**	**9,587**	**9,014**

*** The number of eligible decisions does not directly relate to the number of applications submitted.**