AGENDA

FINANCE COMMITTEE

MEETING DATE: JUNE 12, 2012
TIME: 9:00 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER — **BERNARD ROSEN**

ADOPTION OF THE *MAY 8, 2012* MINUTES

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

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

INFORMATION ITEMS

1. **STATEMENT OF REVENUES & EXPENSES** — **JAY WEINMAN**
   For The PERIOD ENDED MARCH 2012 & 2011

2. **MEDICAID ELIGIBILITY REPORT –APRIL 2012** — **MAXINE KATZ**

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

MINUTES

MEETING DATE: MAY 8, 2012

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on May 8, 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
Robert Doar, Commissioner
Josephine Bolus, RN
Emily Youssouf
Ian Hartman-O'Connell, (representing Deputy Mayor Linda Gibbs in a voting capacity)

OTHER ATTENDEES

J. DeGeorge, Analyst, Office of the State Comptroller
M. Dolan, Senior Assistant Director, DC 37
A. Edwards, President, Commission on the Public Hospital System (CPHS)
C. Fiorentini, Analyst, Independent Budget Office (IBO)
R. McIntyre, Account Executive, Siemens
M. Meagher, Analyst, OMB
J. Wessler, CPHS

HHC STAFF

V. Bekker, Chief Financial Officer (CFO), Generations+ Northern Manhattan Health Network
L. Brown, Senior Vice President, Corporate Planning/HIV Services, Intergovernmental Services, Community Hlth
D. Cates, Chief of Staff, Board Affairs

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, Corporate Managed Care
K. Garramone, Chief Financial Officer, North Bronx Network
L. Guglieri, Senior Director, Jacobi Medical Center
G. Guilford, Senior Director, Office of the Senior Vice President/Finance/Managed Care
E. Guzman, Chief Financial Officer, Metropolitan Hospital Center
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
P. Lockhart, Secretary to the Corporation, Office of the Chairman
R. Malone, Deputy Chief Financial Officer, Queens Hospital Center
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
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
A. Moran, Chief Financial Officer, Elmhurst Hospital Center
D. Moskos, Director, Office of Facilities Development
M. Novzen, Senior Associate Director, Woodhull Medical &Mental Health Center
K. Olson, Deputy Budget Director, Corporate Budget
P. Pandolfini, Chief Financial Officer, Southern Brooklyn Health Care Network
G. Ranghelli, Chief Financial Officer, Coler/Goldwater Specialty Hospital and Nursing Facility
B. Rob.es, Senior Vice President/CIO, Corporate Information Systems
S. Russo, Senior Vice President, General Counsel, Office of Legal Affairs
B. Stacey, Chief Financial Officer, Queens Health Network
J. Wale, Senior Assistant Vice President, Behavioral Health Services
M. Weinberg, Executive Director, Metropolitan Hospital Center
J. Weinman, Corporate Comptroller, Corporate Comptroller's Office
M. Williams, Assistant Vice President, Corporate Affirmative Action/EEO
R. Wilson, Senior Vice President/Corporate Medical Director, Medical & Professional Affairs
M. Zurack, Senior Vice President, Corporate Finance/Managed Care

Minutes of the May 8, 2012 Finance Committee Meeting

CALL TO ORDER:

The meeting of the Finance Committee was called to order at 9:10 a.m. The minutes of the April 3, 2012 Finance Committee meeting were adopted as submitted.

CHAIR'S REPORT **BERNARD ROSEN**

Mr. Rosen asked the Committee to join him in congratulating Mrs. Bolus who was honored by the United Hospital Funds, for its 2012 Distinguished Trustee Award.

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

Ms. Zurack informed the Committee that her report would cover four items. The first of which was that Ms. Jackie Huey, Senior Director, Corporate Revenue Management retired last week. During her thirty year tenure, Ms. Huey made major contributions to the Revenue Management division. She has been and will continue to be a consumer advocate. HHC is extremely proud to have had her as a member of its management team. She will be missed.

Ms. Zurack stated that HHC's cash on hand improved slightly since last month from 42 days to 43 days and is expected to be slightly higher than previously projected by year-end. The third item related to the City's Executive budget which was released last week and includes Programs to Eliminate the Gap (PEG) as previously reported to the Committee in prior months. As part of the January Plan which was presented within the Executive Budget for 2013, a cut of $4.2 million which will result in an additional fifty FTE reduction for HHC. In addition, it is important to note that there is a critical need for restorations in the City Council funding for those programs that will be discussed as part of the 2012 budget hearing for HHC on June 4, 2012. The restorations include; $7.8 million for child health clinics; $1.8 million Mental Retardation & Developmental Disabilities (MRDD); $3.1 million, rapid HIV testing and $78,000, mental health transportation.

Ms. Youssouf asked if the funding was committed by the City Council.

Ms. Zurack stated that the funding had been restored in the FY 12 budget; however, the Council can only restore items one fiscal year at a time. It is important for HHC to get those items restored on an annual basis; otherwise it will result in a reduction in those programs which would be unsustainable. The fourth item which addresses the Citizen Budget Commission (CBC) report that was released in April 2012, entitled, *"Troubling Prognosis for HHC Finances."* In light of the assumptions noted in the report, it is important to summarize for the Committee the details of those findings and to providing some context. As a general statement, it is important to note that the CBC acknowledges the important role that HHC plays and has highlighted to the public the importance of supplemental Medicaid and the potential losses due to cuts in the Disproportionate Share (DSH) funds as part of the federal budget cuts. It is important to note that HHC takes exception to some of the characterizations included in the report and the exclusion of some very notable and pertinent information. It is a very complex topic and the CBC has attempted to summarize a few headlines; however, the policy agenda in taking that approach is not very clear. On the first page of the report the headline as opposed to a scholarly

report notes that HHC expects $1.6 billion in annual revenues through supplemental Medicaid that could be in jeopardy. HHC's financial plan has $1.4 billion in additional Intergovernmental Transfer (IGT) revenue. The plan takes into account federal reform and cuts to DSH for the life of the plan; however, the DSH cuts occur after the life of the plan. There is no explanation in the report explaining the reason for that assumption. The report suggests that the City may choose not to provide the local match, although there is no indication or statement from the City to support that assumption. The report does not implicate Management but it does mention that part of the concerns is due to the rising cost of fringe benefits, pensions and revenue that are increasing, which are all valid concerns that have been raised by HHC over the past few years. Additionally, there is no mentioning of Tier 6.
Mr. Rosen stated that although it is referenced later in the report, Ms. Zurack's assertion is valid given that Tier 6 is expected to provide some savings in the years ahead. Ms. Zurack stated that it does but it is only mentioned as part of HHC's financial plan in the future. Tier 6 is expected to provide some savings; however, HHC did not address that issue in its financial plan given that those savings are expected to kick-in later. A lot of the information referenced in the report relates to a future period which would be relevant to that discussion. On the second page of the report there is a review of utilization statistics that are categorized as "HHC Critical Role." However, the statistics relate solely to the inpatient acute care without any mentioning of the important role HHC plays in providing outpatient services to the uninsured. In terms of the CBC's focus on the healthcare sector in New York, it mentions that HHC provides a significant portion of care to patients citywide who are on Medicaid or uninsured. HHC hospitals care for 30% of Medicaid and uninsured patients admitted to inpatient acute care facilities. While the City's voluntary hospitals care for the majority of the indigent population needing acute care; however, their ability to do that depends largely on the public hospital system. That statement assumes the primary nature of the voluntary sector as the main sector excluding the significant outpatient data that would be entirely HHC and excludes HHC's role in the general healthcare capacity of New York in many ways. However, it does highlight HHC's critical role in mentioning the number of psych, discharges, emergency department visits, and the number of hospital discharges. The report does emphasize the critical role that HHC plays in providing services in New York; however, it understates the absolute essentiality of the care to the uninsured by omitting the outpatient services. The report is very much focused on the perspective of the voluntary hospital sector as the primary provider in New York which is inconsistent with the direction of the healthcare industry. The second major concern is the characterization of the City's funding to HHC. The CBC in its analogy references 1967 as it related to Medicaid and former Mayor John Lindsey's protest that the City had to pay a share of Medicaid, yet it fails to describe the history of HHC which predates Medicaid and the nature of the City's support in 1967 which was 100% of the cost of operating the public hospital system. The City's support for HHC began in 2003 and was catapulted beyond any historical level. During the 1970's and 1980's the City's support to HHC was far greater than currently and before DSH and supplemental Medicaid. Another characterization that is of concern is the way in which the supplemental Medicaid is being defined as an "unwanted obligation" for the City to HHC. However, the City lobbied to get those funds for HHC because the City wanted to have its public hospitals funded and wanted to obtain federal match. In terms of facts, the City's funding as part of the report regarding the supplemental Medicaid which in the write-up, the CBC report attributes the federal share to the City share, which implies that the period prior to 2003, the City has provided much more funding that includes both the City and Federal share as opposed to only the City share which is inaccurate. There is one distributing prognosis which is the characterization of the City's

appropriations, which is referred to by HHC as "Funds Appropriated by the City" are highly discretionary excluding the statutory requirement of the City in providing a subsidy to HHC. There is a dollar amount by law that the City must provide at minimum, $175 million trended forward from 1970.

Ms. Youssouf asked what law is the City mandated to comply with as part of that obligation.
Ms. Zurack stated that the act that created HHC. HHC was created by a State law and in that act there are requirements that the City provide a minimum subsidy to HHC which was established at $175 million in 1970 with reference to the need to adjust for inflation; however, there is no specific methodology relative to calculating that inflation. In addition, the act also references the need for the City and HHC to have an operating agreement, a lease, etc and all those documents were prepared and signed by John Lindsey. Included in those agreements is the City's obligation to provide substantial support to HHC. The City indemnifies HHC for its malpractice; however, HHC chooses to pay the City the cost for that expense even though the City is legally obligation to pay for those expenses. The City is also obligated to pay its bond holders for the debt incurred on HHC buildings. Again, HHC is paying the City for those costs as well. These are not discretionary costs in the City's budget. The CBC's definition of discretionary is inconsistent with the City, in that those subsidies are excluded from HHC's base as part of the Programs to Eliminate the Gap. Therefore, the supplemental Medicaid that the CBC's report identifies as discretionary, the City in its own categorization of discretionary funds puts those funds in a mandated funding category by excluding them from the PEG base that includes $80 million which would be as defined by the City the only amount considered discretionary. While it is understandable that the CBC is looking for facts; however, because of HHC's uniqueness it is difficult to simplify the facts. The strength of the CBC's argument appears to be predicated on the notion that the City is facing dire financial situations which puts HHC's funding from the City at risk. The City is projecting a $3 billion budget gap in FY 14, which is not a historical high budget gap for the City. Notwithstanding, the report highlights the forecast on the Wall Street bonuses but fails to mention the substantial job growth that the City has seen in recent years and the recent improvement in the real estate market that are included in the City's Executive budget.

Ms. Zurack in summarizing stated that it is important for the Board to review this report with the understanding that it highlights some positive contributions made by HHC in terms of the critical role of HHC in the City in providing healthcare and the relevance of supplemental Medicaid to HHC; the support provided by the City; and the capital investments in the City. The rebuilding came at a point when a lot of the original debt that the City had incurred on the original buildings had amortized. The debt service that the City bears that HHC pays to the City for that substantial rebuilding program has been from $150 - $200 million. Therefore, there has not been a significant increase in that level of support. The purpose of presenting these concerns to the Committee was to put into context some of the concerns raised by the report and to highlight some of the mischaracterizations.

Commissioner Doar asked for clarification of the discretionary aspect of the supplemental Medicaid which has always been viewed as the Medicaid match in any other Medicaid provider payment, a local, state and federal share. Ms. Zurack stated that there is no state share but the City at its discretion lobbied the State to give them statutory authority and requirement that are not discretionary to make those supplemental Medicaid payments.

Commissioner Doar asked if it is covered by the changes in the cap legislation on the local share given that it is not discretionary to the City and that it is a State law. Ms. Zurack stated that it is not. Commissioner Doar added that since those payments are not covered by the cap there will either be an increase or a decrease.

Ms. Zurack stated that the City could have a valid argument against the State due to a factor that occurred during that time. The City benefitted from the cap on Medicaid spending significantly; however, the City which is a large urban center with a large population of uninsured has a large public hospital system that was largely affected by the Medicaid cuts that happened as a result of the State budget reductions which largely happened because the State had to bear the Medicaid cost without the counties. In light of that action, the City lobbied the State to have the State increase supplemental Medicaid for HHC and put it in State law so that it is no longer at the City's discretion. As a result of that, the City did not benefit as much from the county cap as other counties in the State that do not have large urban immigrant communities and public hospital systems. Those counties got the benefit of the Medicaid share without increasing their supplemental Medicaid for their public hospitals, such as Eerie, Nassau and Westchester. The benefits of the county cap were not equally distributed because of the DSH for uninsured that are in different part of the state and the need that certain counties had to increase their share of supplemental Medicaid to their public hospitals.

Commissioner Doar stated that if the Mayor characterizes the shift in educational funding over the last five to six years to less State more City; HRA characterizes the shifts in social security spending to less State more City, it would be fair to say the same for the support to HHC.

Ms. Zurack stated that it would be totally fair and that is not reflected in the report. Commissioner Doar added that it is an important piece for the Board to understand. The State's support for the City's social services, hospitals and education has diminished because the State has taken advantage of the City's larger revenue base and if continued, it is not sustainable.

Mrs. Bolus asked whether a rebuttal of the report is being considered.

Dr. Stocker asked if the report was shared with HHC prior to its publication. Ms. Zurack asked Mr. Covino to respond to which he indicated that the report had been reviewed by Finance and there were some changes, particularly the characterization of the discretionary funding but the CBC was only willing to make some of the changes.

Dr. Stocker stated that there should be some type of response to the report given that it will be used as reference material about HHC and in that regard, HHC should consider preparing a formal response.
Ms. Zurack stated that it is not clear at this time whether HHC should respond given that this report may not have gotten a lot of review. The purpose for highlighting some of the concerns is to ensure that the Committee is made aware of the issues.

Dr. Stocker stated that having a prepared response in the event the report is referenced should be considered and the distribution should be more than the Committee and the Board.

Ms. Youssouf also supported the suggestion made by both Dr. Stocker and Mrs. Bolus that a response is important given that a number of people use the CBC report as research and reference material, adding that the CBC's reference to HHC's utilization was not very clear.

Ms. Zurack stated that in terms of the discretionary, the CBC was implying that HHC provides a lot of services to NYC and arguably, what is discretionary for the City is that it is not needed. HHC's critical role is an essential part of the mix. A number of changes at the State and City levels would need to change.

Ms. Youssouf stated it is important for HHC to respond to the report given that there will be a new Mayor in the near future.

Ms. Zurack stated that she was in agreement with the Committee that a response is needed; however, it is important not to make an issue of the report.

Mr. Aviles stated that HHC would decide how to respond to the report whether it is directly to the CBC as opposed to referencing the report in a broader context in which it would be discussed as part of HHC's plan for addressing financial challenges while acknowledging that there are financial issues. However, the problem with the CBC report is that it distorts the essentiality of the system and the City's legal obligation with reference to certain foundational funding for HHC. There is no question that HHC is at risk depending upon how the City's economy plays out going forward. HHC could be left in a position whereby HHC is funded at that amount of money that allows HHC to continue to operate but it does not necessarily allow HHC to maintain one level of care. If the City is faced with the decision between healthcare or law enforcement, education, whether it gets better or worse will play a major factor going forward for HHC. In addressing the Committee recommendations, HHC will decide what will be the best approach in responding to the report to correct some of the inaccuracies and mischaracterizations that would not constitute a rebuttal.

Ms. Zurack stated that another mischaracterization made by the CBC is that HHC's cost containment program from 2009-2010 was modest. HHC has achieved $400 million out of the $600 million reduction which is a significant achievement that should have been highlighted.

Ms. Brown, Senior Vice President, Corporate Planning/HIV Services, Intergovernmental Relations, and Community Health added that the important issue is not whether HHC put together a cogent response or more importantly a cogent iteration of HHC's perspective of these issues but which venue is used to communicate that is of greater importance. It would not be in HHC's best interest to play this out in terms of the media given that it would only bring more attention to the report. As the Committee pointed out, there are different audiences that HHC should make aware of the broader view as opposed to a single one which HHC can decide how to best reach those audiences in a thoughtful, cogent way, including the State.

Commissioner Doar added that the chart included in the report as shown in blue the State and Federal sources, the diminishing support is very clear which is a problem. Mr. Covino stated that the red on the chart implies that it is City but half of that is federal funding.

Ms. Youssouf commented that the Committee's suggestions were not necessarily directed at having a broad response but rather addressing the issues in a cogent way.

Mr. Aviles stated that HHC will decide how to respond and inform the Committee of its action.
After concluding her report, Ms. Zurack asked that the order of the agenda be changed to allow Queens Hospital sufficient time to present its information item that was in response to the Committee's request.

Mr. Rosen stated that given the allotted time, Mr. Covino's reports would be moved to later on the agenda to accommodate the request.

INFORMATION ITEM **BRIAN STACY/ROBERT MALONE**
MEDICAID ELIGIBILITY PROCESSING STATUS REPORT

Ms. Zurack introduced Brian Stacey, Chief Financial Officer, Queens Health Network and Robert Malone, Deputy CFO, Queens Hospital Center.

Mr. Stacey stated that he and Mr. Malone would present to the Committee some of the improvements in the Medicaid application process at Queens Hospital. One of the major improvements in the process has been Breakthrough. This year there were two Rapid Improvement Events (RIE) at the Queens Network and the outcome of those events have had a significant impact on the facility's overall process and performance as reflected in some of the metrics. In terms of some of the basic data, overall the number of applications submitted decreased by 13% from March 2011 to March 2012 and the percentage of Medicaid eligible decisions increased by 1.3% through March 2012. During the same period, discharges declined by 19% due to a reduction in one-day stays at Queens Hospital. Final self-pay decisions after 120 days have also decreased from 12% to 10% resulting in a relative increase in Medicaid application for the reduced discharges. Medicaid applications increased in March 2012 by 9%.
Dr. Stocker asked Mr. Stacey if the 6% increase in Medicaid eligible decision could be quantified for the facility in terms of dollars.

Mr. Malone with some assistance from Ms. Zurack stated that it would be approximately $10,000 per case for total value of $1.2 million.

Ms. Youssouf asked if that amount accounted for the decrease in applications by 13% and eligible decision increased by 6%. Mr. Malone stated that it represented 6% of the discharges.

Mr. Stacey continuing with the presentation stated that the first RIE was a corporate value stream (VS) in the fall 2011 that focused on improving the front-end of the Medicaid application process. In prior practices, self-pay cases were not being interviewed upon admission compared to the current change in process of interviewing the patient at the time of admission in the emergency department (ED). Additionally, in the past, communications between the ED staff, admission and patient accounts were not timely which has been resolved by establishing a self-pay chat group in the GroupWise Messenger as a communication mechanism between those departments. The communication process has

improved significantly as a result of that implementation. Also in the past only HMO cases were being verified at the time of admission and the verification process which was by telephone was very time consuming. To address this issue, standard process and work; whereby, the staff has access to websites and forms to notify the HMOs via fax or website as opposed to telephone which has simplified the process. Before the RIE the base was at zero given that there were no interviews being conducted in the ED on self-pay patients compared to the current process which has shown significant improvement since the RIE, 30 days after the RIE in December 2011 the improvement was at 63% which decreased to 61%; after 90 days of the RIE the percentage increased to 68%. The second RIE addressed the hand-off model in January 2012 at Elmhurst Hospital. The objective was to share best practices which Mr. Malone will present to the Committee.

Mr. Malone stated that the second RIE that took place in January 2012 at Elmhurst, related to the no hand-off model which has been adopted by Queens Hospital. As part of the no-hand-off model, the HCI receives the cases that are for the uninsured patients and maintains them until the accounts receive Medicaid approvals. Those cases are not handed off to another department. Rotational shifts were developed; whereby scheduled coverage for the HCIs from evenings to midnight as well as the weekends and during the day was implemented. The first week of this review process, March 2012, the percentage of Medicaid increased to 79%, increased to 88% after six weeks. Another benefit is that the facility captured about 25% of insured patients in the uninsured base. In terms of further improvements, Admitting has transferred the HMO unit in patient accounts that directly eliminated hand-off duplications as well as administrative denials.

Mr. Malone in response to Ms. Youssouf request for clarification of the hand-off model stated that after interviewing the patient at bedside, the HCI would hand off the account to another investigator in the investigation unit who would contact the family for the required documents. If that process did not occur within thirty days it would be handed-off to another unit, self-pay to pursue. After making changes in that process, there is consistency. The initial HCI will handle the case throughout the Medicaid eligibility process. In terms of the changes, the baseline was at zero through the end of March 16, 2012, the first RIE and after the second RIE there is a significant increase in the ED. In terms of the caseload, the fundamentals for the HCIs who conduct the initial interview as shown on the last page of the presentation initially were scattered in terms of the actual assignments compared to a change in focus, rotation and assigning a specific number of cases. By week eighteen all of the staff had similar cases. The processing of cases has been reduced from 29 to 21 per HCI. This is a distinct advantage at the last reporting to the Committee in July 2011. As reported at that time, there were nine HCIs in the investigations unit compared to the current complement of eight HCIs. One HCI was moved to another area.

Dr. Stocker commented that achieving positive results with less staff is a remarkable improvement; however, would increasing the staff improve the process flow.

Mr. Malone stated that for the hospital's model at this time it would not. If there was an increase in discharges, there might be a need to shift staff back into investigations.

Dr. Stocker asked what the goal is beyond the current improvements. Mr. Malone stated that the goal is to get to 90%.

Dr. Stocker asked if that was related to staffing. Mr. Malone stated that staffing and training would be a factor given that it is based on how well the application is documented that would increase the process flow and ultimately a positive outcome.

Commissioner Doar asked what some of the problems are in getting the applications approved.

Mr. Malone stated that excess income and lack of documentation. Commissioner Doar asked of the two which is more significant. Mr. Malone stated that it would be the ability to obtain the appropriate documentation. Commissioner Doar asked if the documentation is related to citizenship. Mr. Malone stated that it is not but rather the patient's failure to provide the correct information.

Ms. Katz stated that some of those problems have improved due to an improvement on the front-end in the ED and the relaxation of some of documentation requirements by HRA.

Mr. Malone added that the facility has seen consistency with the HCIs who initially interviews the patients. There is confidentiality and the cases do not move to another HCI.

Mrs. Bolus asked if the evening and night staff have the same access to records for HMOs as the day staff.

Ms. Zurack stated that the facility can verify the information but the required notification to the HMO would be the next day since HMOs do not operate 24/7.

Dr. Stocker asked if there is a way to present the percentage of Medicaid eligibility decisions to Medicaid applications submitted in a standardized way across the Corporation.

Ms. Zurack stated that there is a way in that a report could be produce by facility to show the percentage of improvement; however, there will be significant variance due to the lag in the approval process from HRA.

Ms. Youssouf stated that given that the changes at the Queens hospitals have yielded significant outcomes would this be considered a best practice for implementation across the Corporation.

Ms. Katz stated that as previously reported a RIE was done last January and these were two different models. At Elmhurst, the no-hand-off and the other at Lincoln, hand-off that would decrease the amount of hand-offs. These models are being evaluated although both have shown positive outcomes. The next step is to take the two models that were reviewed corporate-wide at each event and do an analysis with the facilities and decide which works best at each hospital.

Ms. Zurack stated that there is a VS Committee that has representation from all of the facilities and information is shared with all of the facilities. There are certain issues with staffing and configuration

that might not make it applicable to each facility. There are many best practices that are being shared with all of the facilities.

Ms. Katz stated that the Value Analysis (VA) looks at all of the data and there have been site visits to each facility and there has been tremendous improvement.

The Queens Hospital presentation was concluded.

Mr. Rosen stated that the next item on the agenda would be the Payor Mix reports given that those reports are not done on a monthly basis but rather quarterly which is important information for the Committee.

MEDICAID ELIGIBILITY INPATIENT PROCESSING REPORT **MAXINE KATZ**
PAYOR MIX REPORT – INPATIENT, ADULT & PEDIATRICS

Ms. Katz stated that the Inpatient Discharge Payor Mix Report shows a slight improvement in the percentage of patients insured to the total compared to last year, from 94% to 95%. There has been a total decrease in the number of discharges from 169,000 to 163,000 this year. Self-pay decreased as well. There are payor shifts between Medicaid and Medicaid managed care.

Mr. Rosen asked what is included in the commercial and other categories. Ms. Katz stated that it would include blue cross, indemnity and included in others would be workers comp, no-fault, prisoners, etc.

Ms. Youssouf asked if the self-pay category also included patient who pay. Ms. Katz stated that it would be uninsured patients who pay. It is basically the payor category regardless of whether the patient pays. By combining HHC Options and self-pay categories would equal the total uninsured count. HHC Options are those patients who are fee scaled by HHC.

Mrs. Bolus asked where the Medicare deductibles were included. Ms. Katz stated that they are included in the Medicare category; however, from an operational perspective, the co-pay and deductible for those patients are fee-scaled by HHC. Moving to the Adult Payor Mix report which shows that overall patients insured to total, there are significant decreases in the number of visits and shifts between Medicaid and Medicaid managed care, however, HHC Options continues to increase.

Commissioner Doar asked what is the difference between the inpatient and outpatient cost per unpaid case.

Ms. Zurack stated that the inpatient would be $3,000 to $50,000 and outpatient, $250.00 to $1,000 per case.

Ms. Katz stated that the pediatrics report showed overall that the percentage of insured to total increased to 96%.

Mr. Hartman-O'Connell asked if there was an explanation for the decrease in visits from year to year. Ms. Katz stated that overall visits have decreased.

Ms. Youssouf asked if other hospitals in the City are also experiencing the same level of decrease in outpatient services.

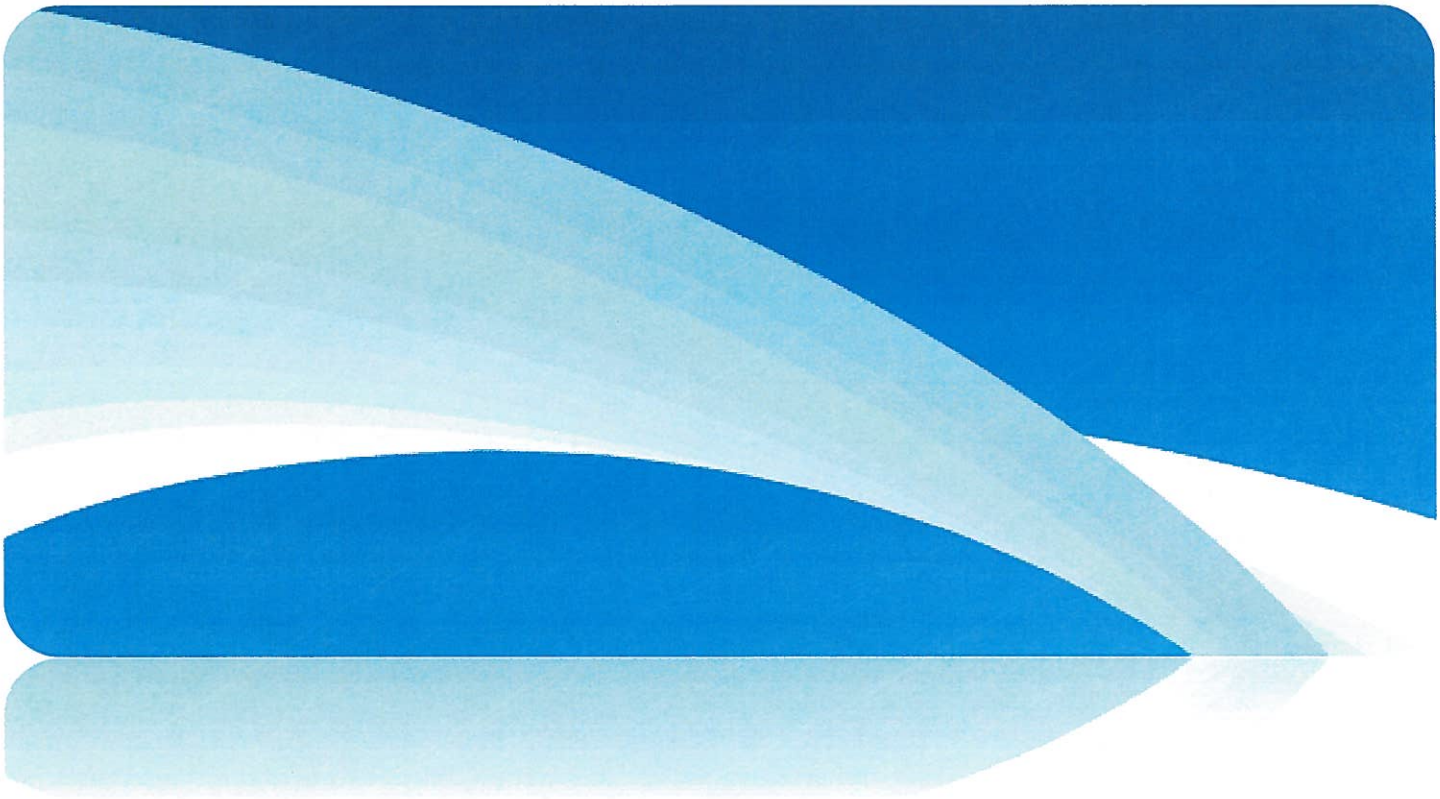
Ms. Zurack stated that the information was not available but that it could be researched and reported back to the Committee.

Ms. Brown added that the data base used to compare hospitals on the outpatient side is not as reliable as the inpatient in addition to being very dated. One factor for the decrease could be that there has been an expansion of federally qualified health centers (FQHC), ambulatory care centers as well as the voluntary hospitals have been shifting their ambulatory care visits to those FQHCs. For HHC the issue relates to capacity and standard weights for outpatient services. Last year, HHC closed six outpatient centers.

Mr. Rosen stated that since the meeting had gone pass the allotted time, the Key Indicators and Cash Receipts and Disbursements reports as of March 2012 would not be reported; however, it was important to note that FTEs were down by 286 against the target which is an important factor in HHC's overall year-end status.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 10:16 a.m.



KEY INDICATORS & CASH RECEIPTS & DISBURSEMENTS REPORTS

KEY INDICATORS
FISCAL YEAR 2012 UTILIZATION

Year to Date
April 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	16,588	16,914	-1.9%	5.9	6.0	1.1233	1.1190
North Central Bronx	6,704	6,629	1.1%	4.3	4.3	0.7291	0.7519
Generations +							
Harlem	8,821	9,809	-10.1%	5.3	5.5	1.0254	0.9765
Lincoln	19,497	21,139	-7.8%	4.8	5.3	0.9520	0.9534
Belvis DTC	55,052	58,418	-5.8%				
Morrisania DTC	80,850	67,742	19.3%				
Renaissance	56,206	63,837	-12.0%				
South Manhattan							
Bellevue	20,822	20,693	0.6%	6.1	6.0	1.1480	1.1871
Metropolitan	9,755	9,726	0.3%	4.6	4.8	0.8010	0.8845
Coler	242,325	281,982	-14.1%				
Goldwater	261,571	267,823	-2.3%				
Gouverneur - NF	56,483	61,094	-7.5%				
Gouverneur - DTC	233,463	264,010	-11.6%				
North Central Brooklyn							
Kings County	20,053	19,367	3.5%	5.8	5.8	1.0691	1.1090
Woodhull	11,660	13,021	-10.5%	5.0	4.7	0.8496	0.8652
McKinney	95,918	94,869	1.1%				
Cumberland DTC	81,435	90,810	-10.3%				
East New York	70,305	72,591	-3.1%				
Southern Brooklyn / S I							
Coney Island	13,846	14,767	-6.2%	6.2	5.8	1.1100	1.1016
Seaview	90,837	90,490	0.4%				
Queens							
Elmhurst	20,382	21,407	-4.8%	5.2	5.1	0.9677	0.9346
Queens	10,811	13,120	-17.6%	5.1	5.0	0.9195	0.8351
Discharges/CMI-- All Acutes	158,939	166,592	-4.6%			1.0009	0.9996
Visits-- All D&TCs	577,311	617,408	-6.5%				
Days-- All SNFs	747,134	796,258	-6.2%				

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
April 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	(94.0)	$ 381,429	$ 20,237	$ 451,638	$ 16,382	$ 36,619	4.4%
North Central Bronx	(7.5)	138,393	14,319	145,990	8,315	22,635	8.1%
	(101.5)	$ 519,822	$ 34,556	$ 597,628	$ 24,697	$ 59,253	5.3%
Generations +							
Harlem	(34.5)	$ 218,756	$ (8,709)	$ 288,748	$ (14,859)	$ (23,568)	-4.7%
Lincoln	8.5	341,285	14,381	408,703	7,359	21,740	2.9%
Belvis DTC	(3.0)	11,943	1,964	12,241	1,704	3,668	15.3%
Morrisania DTC	3.0	19,615	2,921	21,881	4,047	6,968	16.3%
Renaissance	5.0	12,944	725	18,700	523	1,248	4.0%
	(21.0)	$ 604,543	$ 11,282	$ 750,273	$ (1,226)	$ 10,056	0.7%
South Manhattan							
Bellevue	(52.0)	$ 519,296	$ 1,093	$ 592,230	$ (36)	$ 1,056	0.1%
Metropolitan	(51.0)	203,948	(13,103)	258,436	5,410	(7,693)	-1.6%
Coler	(30.0)	78,171	(7,714)	111,938	(13,084)	(20,798)	-11.3%
Goldwater	(35.0)	101,800	(17,156)	146,503	(14,116)	(31,272)	-12.4%
Gouverneur	(24.5)	73,519	(800)	75,810	6,827	6,027	3.8%
	(192.5)	$ 976,734	$ (37,681)	$ 1,184,917	$ (14,999)	$ (52,680)	-2.4%
North Central Brooklyn							
Kings County	(109.5)	$ 529,048	$ 41,960	$ 582,845	$ 2,174	$ 44,134	4.1%
Woodhull	(97.5)	$ 249,778	$ (36,234)	$ 334,193	$ 2,731	$ (33,503)	-5.4%
McKinney	(22.0)	34,795	(1,594)	37,529	(428)	(2,022)	-2.8%
Cumberland DTC	(8.5)	18,566	(924)	27,929	(5,395)	(6,319)	-15.0%
East New York	(3.0)	17,396	750	18,445	1,421	2,171	5.9%
	(240.5)	$ 849,583	$ 3,958	$ 1,000,941	$ 503	$ 4,461	0.2%
Southern Brooklyn/SI							
Coney Island	26.5	$ 242,324	$ 21,876	$ 297,687	$ 5,707	$ 27,584	5.3%
Seaview	(16.0)	32,652	(1,294)	41,248	(38)	(1,332)	-1.8%
	10.5	$ 274,976	$ 20,582	$ 338,935	$ 5,669	$ 26,252	4.4%
Queens							
Elmhurst	(55.5)	$ 398,105	$ (991)	$ 447,910	$ 26,581	$ 25,589	2.9%
Queens	1.0	250,313	18,132	294,516	(18,707)	(575)	-0.1%
	(54.5)	$ 648,418	$ 17,141	$ 742,427	$ 7,874	$ 25,014	1.8%
NETWORKS TOTAL	**(599.5)**	**$ 3,874,076**	**$ 49,837**	**$ 4,615,121**	**$ 22,519**	**$ 72,356**	**0.8%**
Central Office	(248.0)	650,578	1,453	203,220	8,877	10,330	1.2%
HHC Health & Home Care	8.0	16,563	(7,446)	31,048	326	(7,120)	-12.9%
Enterprise IT	542.0	0	0	117,404	6,845	6,845	5.5%
GRAND TOTAL	**(297.5)**	**$ 4,541,217**	**$ 43,844**	**$ 4,966,793**	**$ 38,567**	**$ 82,411**	**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 April 2012			Fiscal Year To Date April 2012		
	actual 2012	actual 2011	better / (worse)	actual 2012	actual 2011	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 80,028	$ 121,111	$ (41,083)	$ 906,693	$ 984,899	$ (78,206)
Medicaid Managed Care	44,731	53,914	(9,183)	480,963	496,565	(15,602)
Medicare	44,415	38,389	6,026	471,626	435,968	35,658
Medicare Managed Care	17,860	26,518	(8,658)	209,775	212,325	(2,550)
Other	19,866	19,941	(75)	193,647	187,528	6,119
Total Inpatient	$ 206,900	$ 259,873	$ (52,973)	$ 2,262,704	$ 2,317,285	$ (54,581)
Outpatient						
Medicaid Fee for Service	$ 15,014	$ 25,345	$ (10,331)	$ 166,897	$ 207,866	$ (40,970)
Medicaid Managed Care	84,830	36,812	48,018	364,132	290,248	73,884
Medicare	5,230	4,920	310	55,999	53,045	2,954
Medicare Managed Care	5,955	5,777	177	80,995	66,098	14,897
Other	20,198	12,110	8,089	133,509	118,824	14,685
Total Outpatient	$ 131,227	$ 84,964	$ 46,262	$ 801,531	$ 736,081	$ 65,451
All Other						
Pools	$ (1,854)	$ 88,941	$ (90,794)	$ 329,265	$ 431,611	$ (102,345)
DSH / UPL	-	-	-	883,056	1,107,686	(224,630)
Grants, Intracity, Tax Levy	17,507	16,045	1,462	206,706	206,960	(253)
Appeals & Settlements	25,693	(1,084)	26,778	13,719	44,620	(30,901)
Misc / Capital Reimb	4,260	4,781	(521)	44,234	49,325	(5,091)
Total All Other	$ 45,606	$ 108,682	$ (63,075)	$ 1,476,981	$ 1,840,202	$ (363,221)
Total Cash Receipts	**$ 383,733**	**$ 453,519**	**$ (69,786)**	**$ 4,541,217**	**$ 4,893,568**	**$ (352,351)**
Cash Disbursements						
PS	$ 185,702	$ 279,156	$ 93,454	$ 2,060,335	$ 2,094,820	$ 34,486
Fringe Benefits	78,047	64,179	(13,868)	830,410	777,305	(53,105)
OTPS	92,423	96,130	3,707	1,022,592	996,926	(25,666)
City Payments	-	-	-	250,113	182,956	(67,157)
Affiliation	72,965	72,218	(747)	726,418	704,232	(22,186)
HHC Bonds Debt	6,990	8,271	1,281	76,926	78,997	2,071
Total Cash Disbursements	**$ 436,127**	**$ 519,954**	**$ 83,827**	**$ 4,966,793**	**$ 4,835,236**	**$ (131,558)**
Receipts over/(under) Disbursements	**$ (52,394)**	**$ (66,435)**	**$ 14,042**	**$ (425,577)**	**$ 58,332**	**$ (483,909)**

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

	Month of April 2012			Fiscal Year To Date April 2012		
	actual 2012	budget 2012	better / (worse)	actual 2012	budget 2012	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 80,028	$ 95,278	$ (15,251)	$ 906,693	$ 946,512	$ (39,819)
Medicaid Managed Care	44,731	50,174	(5,443)	480,963	509,214	(28,251)
Medicare	44,415	37,015	7,401	471,626	429,377	42,249
Medicare Managed Care	17,860	20,967	(3,107)	209,775	205,678	4,097
Other	19,866	18,864	1,002	193,647	185,052	8,595
Total Inpatient	$ 206,900	$ 222,299	$ (15,399)	$ 2,262,704	$ 2,275,833	$ (13,129)
Outpatient						
Medicaid Fee for Service	$ 15,014	$ 17,910	$ (2,896)	$ 166,897	$ 192,454	$ (25,557)
Medicaid Managed Care	84,830	71,483	13,347	364,132	318,817	45,315
Medicare	5,230	5,295	(65)	55,999	58,306	(2,307)
Medicare Managed Care	5,955	5,708	246	80,995	81,454	(459)
Other	20,198	18,735	1,463	133,509	122,317	11,191
Total Outpatient	$ 131,227	$ 119,131	$ 12,096	$ 801,531	$ 773,349	$ 28,183
All Other						
Pools	$ (1,854)	$ (1,850)	$ (4)	$ 329,265	$ 326,283	$ 2,982
DSH / UPL	-	-	0	883,056	883,056	(0)
Grants, Intracity, Tax Levy	17,507	14,406	3,101	206,706	199,337	7,370
Appeals & Settlements	25,693	-	25,693	13,719	(6,671)	20,390
Misc / Capital Reimb	4,260	4,631	(372)	44,234	46,186	(1,952)
Total All Other	$ 45,606	$ 17,188	$ 28,419	$ 1,476,981	$ 1,448,191	$ 28,790
Total Cash Receipts	**$ 383,733**	**$ 358,617**	**$ 25,116**	**$ 4,541,217**	**$ 4,497,372**	**$ 43,844**
Cash Disbursements						
PS	$ 185,702	$ 184,634	$ (1,068)	$ 2,060,335	$ 2,052,976	$ (7,358)
Fringe Benefits	78,047	78,204	157	830,410	836,358	5,948
OTPS	92,423	96,183	3,760	1,022,592	1,062,376	39,783
City Payments	-	-	-	250,113	249,507	(606)
Affiliation	72,965	71,389	(1,576)	726,418	724,512	(1,906)
HHC Bonds Debt	6,990	7,963	973	76,926	79,630	2,704
Total Cash Disbursements	**$ 436,127**	**$ 438,373**	**$ 2,246**	**$ 4,966,793**	**$ 5,005,360**	**$ 38,567**
Receipts over/(under) Disbursements	**$ (52,394)**	**$ (79,756)**	**$ 27,362**	**$ (425,577)**	**$ (507,988)**	**$ 82,411**

INFORMATION ITEM

1

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of the City of New York)

Statement of Revenue and Expenses

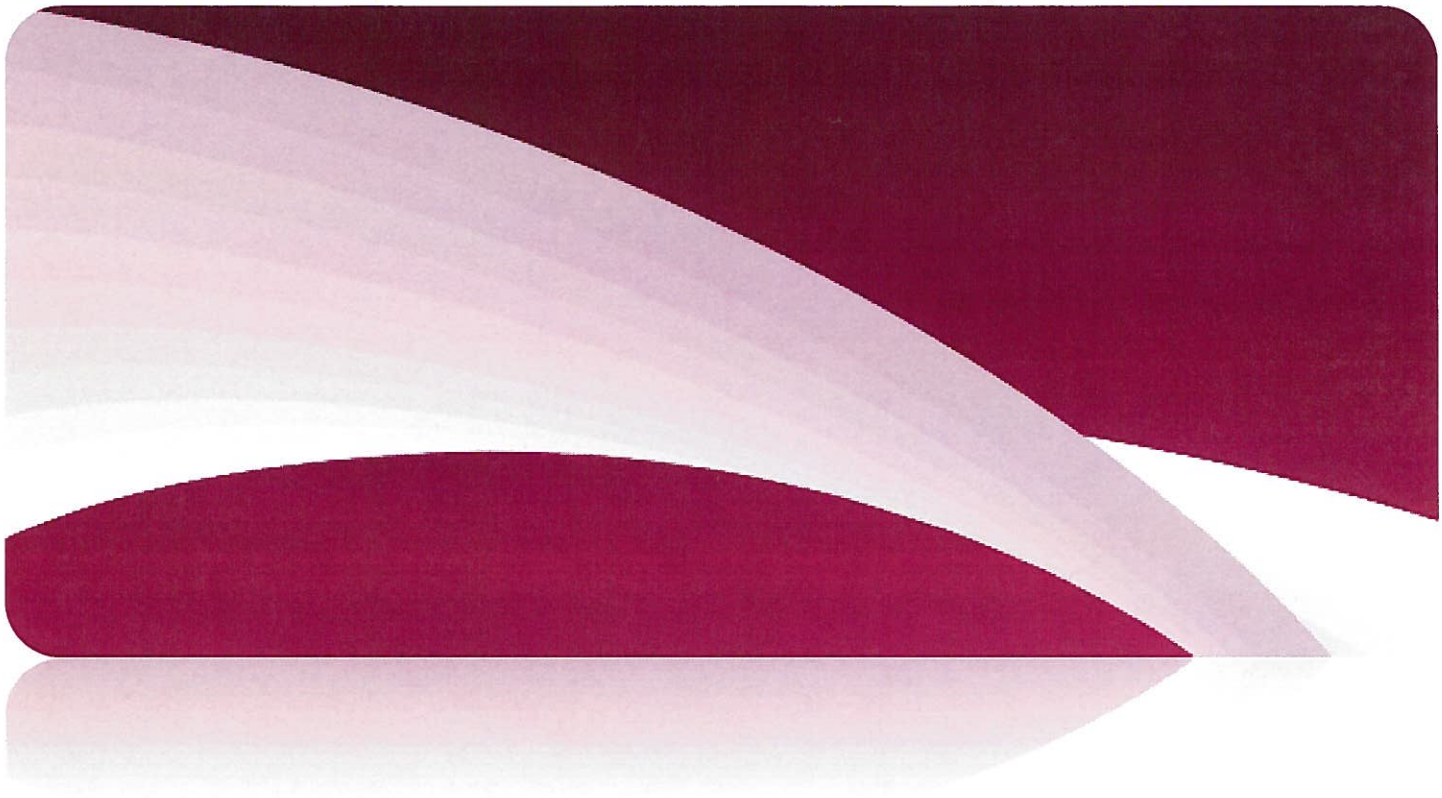
Periods ended March 31, 2012 and 2011

(in thousands)

	HHC		MetroPlus		Inter-Company Elimination Entries		Totals		
	2012	2011	2012	2011	2012	2011	2012	2011	Variance
Operating revenues:									
Net patient service revenue	$ 4,208,239	4,417,301	-	-	(532,535) (1)	(443,599) (1)	3,675,704	3,973,702	(297,998)
Appropriations from (remittances to) the City, net	(5,879)	19,815	-	-	-	-	(5,879)	19,815	(25,694)
Premium revenue	-	-	1,350,833	954,415	(11,502) (2)	(9,932) (2)	1,339,331	944,483	394,848
Grants revenue	171,866	146,805	(25)	164	-	-	171,841	146,969	24,872
Other revenue	31,431	34,660	31	4	-	-	31,462	34,664	(3,202)
Total operating revenues	4,405,657	4,618,581	1,350,839	954,583	(544,037)	(453,531)	5,212,459	5,119,633	92,826
Operating expenses:									
Personal services	1,786,202	1,920,914	35,524	34,724	-	-	1,821,726	1,955,638	(133,912)
Other than personal services	1,028,398	1,030,228	1,233,013	848,606	(532,535) (1)	(443,599) (1)	1,728,876	1,435,235	293,641
Fringe benefits and employer payroll taxes	820,062	773,372	14,793	12,785	(11,502) (2)	(9,932) (2)	823,353	776,225	47,128
Postemployment benefits, other than pension	516,968	424,613	7,462	5,287	-	-	524,430	429,900	94,530
Affiliation contracted services	653,452	626,579	-	-	-	-	653,452	626,579	26,873
Depreciation	189,705	187,752	1,350	1,229	-	-	191,055	188,981	2,074
Total operating expenses	4,994,787	4,963,458	1,292,142	902,631	(544,037)	(453,531)	5,742,892	5,412,558	330,334
Operating income (loss)	(589,130)	(344,877)	58,697	51,952	-	-	(530,433)	(292,925)	(237,508)
Nonoperating revenues (expenses):									
Investment income	7,332	10,224	1,163	984	-	-	8,495	11,208	(2,713)
Interest expense	(75,050)	(67,968)	-	-	-	-	(75,050)	(67,968)	(7,082)
Noncapital contributions	732	480	-	-	-	-	732	480	252
Total nonoperating revenues (expenses)	(66,986)	(57,264)	1,163	984	-	-	(65,823)	(56,280)	(9,543)
Income (Loss)	$ (656,116)	(402,141)	59,860	52,936	-	-	(596,256)	(349,205)	(247,051)

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

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



INFORMATION ITEM

2

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

	Fiscal Year To Date As of April 2012					
FACILITY	Medicaid Applications Submitted	Medicaid Eligible Decisions*	Ineligible Decisions	Addt'l Info Requested	PCAP Applications Submitted	Perinatal Care Assistance Program (PCAP) Eligible
BELLEVUE	4,427	3,506	523	374	573	509
CONEY ISLAND	2,268	1,952	104	91	577	554
ELMHURST	4,071	4,036	94	57	2,328	2,276
HARLEM	1,281	1,114	52	76	381	408
JACOBI	2,675	2,268	327	60	825	809
KINGS	3,885	3,625	137	122	1,454	1,467
LINCOLN	2,517	2,351	80	134	1,085	1,033
METROPOLITAN	1,779	1,513	100	84	827	840
NCB	1,149	1,111	53	48	818	824
QUEENS	2,170	1,976	110	102	885	929
WOODHULL	1,974	1,833	75	97	954	945
TOTAL	28,196	25,285	1,655	1,245	10,707	10,594

	Fiscal Year To Date As of April 2011					
FACILITY	Medicaid Applications Submitted	Medicaid Eligible Decisions*	Ineligible Decisions	Addt'l Info Requested	PCAP Applications Submitted	Perinatal Care Assistance Program (PCAP) Eligible
BELLEVUE	4,901	4,187	341	350	814	688
CONEY ISLAND	2,114	1,742	142	201	691	642
ELMHURST	4,050	3,611	91	82	2,510	2,440
HARLEM	1,387	1,215	76	139	494	469
JACOBI	2,539	2,059	171	177	1,118	1,044
KINGS	3,698	3,287	213	249	1,756	1,587
LINCOLN	2,790	2,649	47	113	1,100	1,073
METROPOLITAN	2,058	1,668	192	153	821	782
NCB	1,137	1,018	62	46	806	829
QUEENS	2,499	2,130	93	194	1,171	1,095
WOODHULL	2,099	1,943	81	106	958	929
TOTAL	29,272	25,509	1,509	1,810	12,239	11,578

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