FINANCE COMMITTEE AGENDA

Date: January 11, 2018
Time: 12:00 Noon
Location: 125 Worth Street, Board Room

Call to Order — Bernard Rosen
Adoption of the November 8, 2017 Minutes

I. Senior Vice President's Report — PV Anantharam

II. Financial Reports Status
- Key Indicators — Krista Olson
- Cash Receipts and Disbursements — Michline Farag

III. Action Item — Linda Dehart
Authorizing the New York City Health and Hospitals Corporation (the "System") to negotiate and execute a contract with Public Financial Management, Inc. ("PFM") to provide financial advisory and other business consulting services for an amount not-to-exceed $170,000 per annum for a three year term, with two, one-year renewal options, solely exercisable by the System.

IV. Information Items
- Short Term Financing Update — Linda Dehart
- Huron Update — PV Anantharam, Graham Gulian

Old Business
New Business — Bernard Rosen
Adjournment

MINUTES

Finance Committee **Meeting Date: November 8, 2017**

Board of Directors
The meeting of the Finance Committee of the Board of Directors was held on November 8, 2017 in the 5th floor Board Room with Bernard Rosen presiding as Chairperson.

ATTENDEES
COMMITTEE MEMBERS
Bernard Rosen
Stan Brezenoff
Helen Arteaga Landaverde
Barbara Lowe
Mark Page
Emily Youssouf

OTHER MEMBER
Josephine Bolus

OTHER ATTENDEES
J. Cassidy, OMB
C. Chen, OMB
J. DeGeorge, Office of the State Comptroller
J. Merrill, City Council
A. Mirdita, CFO, PAGNY

HHC STAFF
P. Albertson, Vice President, Supply Chain Services
P.V. Anantharam, Senior Vice President/CFO, Corporate Finance
E. Barlis, CFO, Jacobi
R. Colon, Chief People Officer
E. Cosme, CFO, Gotham
J. Cuda, CFO, MetroPlus
F. Covino, Senior Assistant Vice President, Corporate Budget
L. Dehart, Assistant Vice President, Corporate Reimbursement Services
M. Farag, Corporate Budget Director, Corporate Budget
S. Fass, AVP, Central Office
M. Figueroa, CFO, Harlem
R. Fischer, CFO, Bellevue
D. Guzman, CFO, Elmhurst
C. Hercules, Chief of Staff, Chairperson's Office
B. Ingraham-Roberts, Assistant Vice President, Government and Community Affairs

M. Katz, Assistant Vice President, Revenue Management
C. Keeley, Director, Central Office
P. Lockhart, Secretary to the Corporation, Office of the
Chairman P. Lok, Senior Director, Corporate Finance
F. Long, CFO, Carter
S. Loville, Corporate Budget
N. Mar, Director, Reimbursement
A. Marengo, SVP, Communications
K. Olson, Assistant Vice President, Corporate Budget
A. Pai, Chief of Staff to the SVP Finance/CFO
S. Russo, Senior Vice President/General Counsel
S. Samis, Chief of Staff, President's Office
S. Shaw, Director, Central Office Finance
E. Soiman, CFO, Woodhull
B. Stacey, CFO, Lincoln
J. Weinman, Corporate Comptroller, Corporate Finance
R. Zhu, Senior Associate Director, Metropolitan

CALL TO ORDER **BERNARD ROSEN**

Mr. Bernard Rosen called the meeting to order at 12:04pm. The minutes of the September 13, 2017 meeting were approved as submitted.

SENIOR VICE PRESIDENT'S REPORT **P.V. ANANTHARAM**

Mr. PV Anantharam began his report noting that last month KPMG completed its audit of the 2017 financial statement, and it was presented to the Audit Committee. The audit was released to the Comptroller as part of the City's Comprehensive Annual Financial Report (CAFR), and the full 70 page audit report is available on the city Comptroller's website. (https://comptroller.nyc.gov/services/financial-matters/nyc-component-units-financial-statements/) Mr. Anantharam provided a brief overview of the financials for Fiscal Year 2017. The Net Patient Service Revenue decreased by $148 million as a result of prior year DSH revenue in 2016 which is non-recurrent in 2017; in-patient utilization also decreased by 2.5% which is also reflected in the numbers. Appropriations from the City were $723 million and reflects a decrease from the prior year. These changes are due to an increase to the 2016 subsidies that were originally planned for 2017. Grants revenue increased $502 million due to additional grant funding consisting of city and federal funds for $140 million Delivery System Reform Incentive Payment (DSRIP) and a little over $400 million in Value Based Payment Quality Improvement Program (VBP/QIP) and Care Restructuring Enhancement Pilot (CREP) funds, of which half are City funds. Personal services remained relatively flat due to headcount control efforts; generally, in other circumstances, PS would have increased over the past three years on 4.5% on average. Other than personal services increased by $311 million, or 8.5%, of which $169 million is a MetroPlus increase, primarily due to an increase in its members. Fiscal Year 2017 ended with a decrease of $194 million in net position of which $313 million was non-cash with no impact on regular operating flow; this position would have been better if utilization held steady through the year.

The expected year end cash balance had been about $200 million, but Health + Hospitals ended at $600 million. This was partially because the City gave Health + Hospitals additional funds near the end of FY17, and the gap closing initiatives, including the full time employee (FTE) reductions, the revenue cycle initiatives launched last fiscal year which yielded $100 million, and the grant revenues from VBP and CREP. Overall, it was a successful year considering where Health + Hospitals had started.

Mr. Anantharam noted that Ms. Linda Dehart would provide an update on the interaction with the State on the expected DSH revenue of approximately $380 million. Through the efforts of Mr. Brezenoff, City Hall, OMB, and the press and legal teams, Health + Hospitals reached an agreement with the State that addresses all of the DSH funds that were being withheld. Ms. Dehart provided an update on the DSH funds release with the State. It had been estimated the amount of funding to be approximately $380 million, but the actual amount is $387 million. The State is paying $268 million in equal payments over the next 3 months, through December. The payment schedule for the $119 million balance will be set in January, as the State has acknowledged that Health + Hospitals is due that funding, and committed to completing payment by the end of the City Fiscal Year. The $360 million figure mentioned in press accounts is the total amount of DSH payments Health + Hospitals will receive through December. It is comprised of the $268 million and $92 million of other DSH funds that were already scheduled for payment and were anticipated in our budget. With this issue behind Health + Hospitals, Health + Hospitals can focus with the State and other partners on supporting efforts to further delay the federal cuts. Ms. Lowe asked what we had to look forward to with the State, and would there have to be continued lobbying to obtain funds. Ms. Dehart noted that the $119 million

was acknowledged as due to Health + Hospitals; the rest will depend on the federal level which will have to be advocated and lobbied for.

Mr. Brezenoff emphasized two things from the Senior Vice President's report. First, the virtual flat personal services expenses is unheard of in healthcare, particularly with the collective bargaining increases that kicked in. This was achieved through personnel management in which Health + Hospitals met or exceeded the headcount reduction targets. Second, the cash position at the end of the year is important as Health + Hospitals carries that over into the new fiscal year. Mr. Anantharam noted that in regards to DSH, Health + Hospitals hopes to stave off cuts and will work with the State if the cuts are implemented. Ms. Lowe asked if there was a legislative proposal to increase funding. Mr. Anantharam noted it may have been included in the House bill, and that the Senate may be taking it up shortly. Mr. Anantharam finished his report by noting the cash balance being about $400 million in early November with continuing reliance on supplemental payments throughout the year, and that Health + Hospitals must maintain vigilance on the cash position. With no further questions, the reporting was concluded.

KEY INDICATORS REPORT **KRISTA OLSON**

Ms. Krista Olson began reporting on FY18 utilization through September compared to the prior year. Ms. Olson noted that variations in facilities for the first three months may be greater than the rest of the year. Starting with acute care hospitals, ambulatory care visits are down by 2.9% compared to the year-end -4.9%. This remains a decline compared to last year, and consistent with the last report; facilities report vacancies in provider lines contributed to the decline.

Inpatient discharges are down by 3.2%, similar to the year end -2.6%. The largest declines are at Harlem and Metropolitan. Both facilities have seen commensurate increases in observation encounters that offset these declines, so it is not necessarily a decrease in overall volume or the patients being seen. Ms. Youssouf asked for more information on that. Ms. Olson noted that if a patient comes in and does not meet the criteria for admission, and if the facility has an observation unit that the patient stays in observation status with an observation rate which impacts revenue. Ms. Youssouf asked if those observations are counted as discharges, and Ms. Olson noted that they are counted in outpatient visits. Ms. Youssouf asked if there was anything in particular with Woodhull numbers. Ms. Olson noted that there was a decline across the services which is a continuation from last year. Ms. Arteaga Landaverde asked if what was happening at Woodhull was ideal, and Ms. Olson replied no. Mr. Anantharam noted that there is an effort to recruit physicians, and once the efforts take hold, the numbers should increase.

Ms. Arteaga Landaverde noted that she also sat on the Quality Assurance Committee meeting, and that Harlem and Metropolitan had low provider vacancies from what she recalled. Ms. Olson noted that the Harlem and Metropolitan declines were on the inpatient side which is offset by the increase in observations. Ms. Youssouf noted that Harlem's 8.8% decrease in discharges and 3.5% decrease in visits are not necessarily compensating. Ms. Olson noted that visits are a much higher number in terms of volume, over 70,000, and the inpatient discharges are only a few thousand. Mr. Brezenoff noted that observations stays are a policy decision – it may be a good practice clinically but it is not compensated well. Observation stays need to be compensated differently. Mr. Page noted that there is a repeating pattern that practice is enlightened in Health + Hospitals but revenue is not realized by Health + Hospitals. Mr. Brezenoff noted that it likely cost revenue under the old system, and Health + Hospitals is likely coming out behind on this.

Ms. Oslon reported that the Average Length of Stay shown in this month's report is using a new methodology. The actual length of stay no longer excludes either one day stays or longer-stay outliers. It does continue to exclude psychiatry and rehab. The expected length of stay is now comparing to the NYC external hospital average – adjusted for the facility specific case-mix. This new methodology allows for drill-down and transparency. Overall, H+H LOS is ½ of one day above the city-wide average; with 6 facilities greater than their corresponding benchmark and 5 facilities below. As noted before, this new methodology for greater transparency in how it is calculated and to begin to understand areas for improvement. Ms. Lowe asked if Health + Hospitals was unique in terms of the patients being served. Ms. Olson noted that to answer Ms. Lowe's question, the reasons for why Health + Hospitals has a higher length of stay are likely a combination of differences in the patients served including greater homelessness and other socio-economic characteristics that may make it more difficult for them to be discharged; documentation and coding differences; and discharge planning processes that could be improved. Ms. Youssouf asked if this was true in some facilities and not others. Ms. Olson noted that it was likely true for all in varying degrees.

Finally, case mix index (CMI) is up by 2.9% against last year at this time. This appears to be in part due to a large increase at Harlem hospital, which would correspond to the increase in observation and decrease in acute discharges mentioned earlier. The majority of other hospitals are also experiencing increases in CMI likely due to improvement in documentation and coding related to some of the revenue cycle initiatives implemented last year such as secondary diagnosis and targeted Diagnosis Related Group (DRG).

Gotham Diagnostic and Treatment Center visits continue to decline, with visits down 10.2% compared to this time last year with the year-end at -7.5%. Renaissance continues its steep decline at 8.4%, but Gouverneur and East New York are particularly large as well. For Gouverneur, provider vacancies may be contributing to that decline, and new providers are being onboarded.

Post Acute Care services, which ended on a positive note last year, is now also negative. Days are down slightly by .9%. 12.26 Carter has a decline of 4.8% which is due to their LTAC with nursing home days flat. With no further questions, the reporting was concluded.

CASH RECEIPTS & DISBURSEMENTS REPORT **MICHLINE FARAG**

Mr. Rosen noted that there had been great progress on headcount reductions, with over 4,000 management positions reduced. Mr. Fred Covino confirmed that since November 2015, global full-time equivalent positions had decreased by over 4,400. Ms. Michline Farag continued the reporting on FY18 actuals to FY17 actuals through September. For direct patient care receipts, Health + Hospitals is doing better in the first quarter compared to last fiscal year. Inpatient Receipts are up $3.6 million and Outpatient Receipts are $27 million higher. The impact of the revenue cycle initiatives are seen here, with the initiatives rolled out at this time last year.

Overall Receipts in FY18 through September are $315 million lower than last year; this is due to pools timing. For risk pools, Health + Hospitals received $93 million more in the first quarter of FY17 due to a large Metroplus payment of $75 million. A HealthFirst payment was made in June of this year which counts in the last fiscal year. Ms. Youssouf asked why the timing was off. Mr. Covino noted that last year Metroplus advanced $75 million because of Health + Hospitals request due to its cash position. At this time last year, Health + Hospitals received $256.7 million more this year in DSH/UPL.

For Total Cash Disbursements, Health + Hospitals is $109 million higher than last fiscal year, due to a City payment made for $136.7 million in the first quarter of FY18, and no City payment had been paid in the first quarter of FY17. Ms. Rosen asked if the City payment was made earlier this year, and Ms. Farag confirmed it had been. Personnel Services is down by $101 million as FY17 had one extra payroll of $88 million.

For FY18 Quarter 1 actual receipts and disbursements against budget Receipts, Health + Hospitals is $18 million better than budget in patient care receipts. That is $10 million better in inpatient and $8 million better in outpatient receipts. For Cash Disbursements it is on target with a $6 million variance that is less than a half percent away from budget.

Ms. Youssouf requested a further explanation as it relates to outpatient decreases and the number of discharges. Mr. Anantharam noted that to see the changes in dollars related to utilization, a look into the actuals versus the actuals from the prior page would be more helpful. For the first quarter, the impact of the revenue initiatives in this fiscal year is being seen. Mr. Page asked if the acceleration is due to the revenue initiatives, and are they one shots. Mr. Anantharam confirmed yes, and that some are one shots and others are ongoing. One major initiative includes the reduction in days in accounts receivable which had exceeded 70 days. It is now down to about 60 days, including in-house days, with each day approximately valued at $7 million. Mr. Page asked if we could maintain this performance, and Mr. Anantharam answered affirmatively. Ms. Arteaga Landaverde asked if the Huron consulting firm would help on these efforts. Mr. Anantharam noted yes and that there was a lot of work ahead, but that this work is outside of that and that weekly reports on A/R days by facility are currently sent out. Ms. Lowe asked what could be done to reduce the wait time on coding. Mr. Anantharam noted that more coding was occurring with more coders, and that maximizing opportunities in coding was important as well. Health + Hospitals is working with Huron on what is happening in the field. Mr. Brezenoff noted that the work is prioritized for local management. Ms. Bolus asked how far Health + Hospitals can go back for billing. Mr. Anantharam noted that it depends on the payor, but generally one year for Medicare and 90 days for Medicaid, with 180 days for managed care contracts. Mr. Page asked about the similarity in cash disbursements in terms of payments. Mr. Covino answered it is consistent about five days after payroll with days in Accounts Payable creeping up.

PAYOR MIX REPORT **KRISTA OLSON**

Ms. Olson began reporting on the first quarter of Fiscal Year 2018 payor mix report. Inpatient is seeing a slight uptick in Medicare as well as uninsured in this report. Ms. Olson cautioned leaping to any great conclusions given that this represents only three months of data and that this was reported on this one month later last year. Inpatient applications in particular have some lag time before converting from uninsured to insured and that is likely a factor in the reduced performance this year.

One methodological change in the payor mix report has also been made. The threshold of the age of pediatric patients has been changed to be 18 and younger to align with Child Health Plus (CHP) eligibility; in prior years, it had been 19 and younger. There is no major impact from this methodological change. The Outpatient Adult Payor Mix shows a slight positive improvement with a shift of patients. There is also a slight downward trend in Commercial. Ms. Youssouf asked what was in the other category, and if Health + Hospitals gets paid eventually. Ms. Olson noted that the other category includes workman's comp, prisoners, and uniformed services. Mr. Page noted that Health + Hospitals does get paid for the prisoner population, and Ms. Olson confirmed that Health + Hospitals bills Medicaid through a City process. Mr. Page asked if Health + Hospitals gets paid for uniformed services, and Ms. Olson answered payment comes through the City as part of the City

subsidy. Mr. Page asked if the cash amount is driven by services provided or is it just designated as a portion of the City subsidy, and Mr. Anantharam noted that it was the latter. Outpatient pediatrics mimics adults, including a shift to Medicaid Managed Care and a slight decline in Commercial.

Before the meeting close, Mr. Anantharam noted that a Huron presentation would be done the next time that the Finance Committee meets. With no further questions, the reporting was concluded.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 12:43 p.m.

KEY INDICATORS

FISCAL YEAR 2018 UTILIZATION

Year to Date
November 2017

	UTILIZATION						AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	VISITS			DISCHARGES						
	FY 18	FY 17	VAR %	FY 18	FY 17	VAR %	ACTUAL	EXPECTED	FY 18	FY 17
Acute										
Bellevue	237,324	237,956	-0.3%	9,155	9,231	-0.8%	5.6	5.0	1.2351	1.2617
Coney Island	132,081	136,559	-3.3%	5,584	5,733	-2.6%	6.5	5.0	1.0177	1.0235
Elmhurst	239,058	243,262	-1.7%	7,714	7,476	3.2%	5.9	4.9	1.0146	0.9782
Harlem	125,074	126,434	-1.1%	4,613	4,902	-5.9%	5.4	4.6	1.0010	0.9220
Jacobi	167,627	170,014	-1.4%	7,502	7,327	2.4%	5.6	5.2	1.0728	1.0863
Kings County	274,399	275,520	-0.4%	7,595	7,931	-4.2%	6.1	5.0	1.0530	1.0411
Lincoln	216,586	218,177	-0.7%	8,745	8,912	-1.9%	4.4	4.6	0.9733	0.9348
Metropolitan	148,405	156,995	-5.5%	3,305	3,834	-13.8%	4.6	4.8	0.9967	0.9596
North Central Bronx	85,138	84,143	1.2%	2,828	2,718	4.0%	3.8	4.0	0.7046	0.6906
Queens	171,672	162,959	5.3%	5,380	5,374	0.1%	4.3	4.6	0.8463	0.7880
Woodhull	170,621	188,177	-9.3%	4,198	4,422	-5.1%	5.1	4.7	0.9151	0.8971
Acute Total	**1,967,985**	**2,000,196**	**-1.6%**	**66,619**	**67,860**	**-1.8%**	**5.3**	**4.8**	**1.0160**	**0.9946**
Gotham	VISITS									
Belvis DTC	20,855	21,096	-1.1%							
Cumberland DTC	26,493	26,661	-0.6%							
East New York	29,922	32,772	-8.7%							
Gouverneur DTC	88,870	98,444	-9.7%							
Morrisania DTC	31,272	32,438	-3.6%							
Renaissance	13,729	14,677	-6.5%							
Gotham Total	**211,141**	**226,088**	**-6.6%**							
Post Acute Care				DAYS						
Coler				109,266	113,292	-3.6%				
Gouverneur SNF				35,522	33,852	4.9%				
H.J. Carter				45,278	47,915	-5.5%				
McKinney				47,690	46,784	1.9%				
Seaview				45,436	46,013	-1.3%				
Post Acute Care Total				**283,192**	**287,856**	**-1.6%**				
Discharges/CMI-- All Acutes				**66,619**	**67,860**	**-1.8%**			**1.0160**	**0.9946**
Visits -- All DTCs & Acutes	**2,179,126**	**2,226,284**	**-2.1%**							
Days-- All SNFs				**283,192**	**287,856**	**-1.6%**				

Utilization

Discharges: exclude psych and rehab

Visits: Beginning with the November 2015 Board Report, FY17 and FY18 utilization is now based on date of service, and includes open visits. HIV counseling visits that are no longer billable have been excluded. Visits continue to include Clinics, Emergency Department and Ambulatory Surgery.
LTC: SNF and Acute days

Average Length of Stay(LOS)

Previous LOS calculations excluded one-day stays and outliers. Expected length of stay was based on H+H system average adjusted for case-mix.
As of September 2017, Actual LOS includes all stays, regardless of length.
Calculation is as follows:
Actual: days divided by discharges; excludes psych and rehab
Expected: Expected Length of Stay based on New York City SPARCS data, using facility specific case-mix

All Payor CMI

Acute discharges are grouped using New York State APR-DRGs version 32

KEY INDICATORS

FISCAL YEAR 2018 BUDGET PERFORMANCE ($s in 000s)

Year to Date
November 2017

	GLOBAL FTEs		RECEIPTS		DISBURSEMENTS		BUDGET VARIANCE	
	Jun 17	Nov 17*	actual	better / (worse)	actual	better / (worse)	better / (worse)	
Acute								
Bellevue	5,497	5,433	$ 289,429	$ 11,121	$ 336,014	$ (5,102)	$ 6,018	1.0%
Coney Island	3,038	2,976	124,942	3,774	171,766	(561)	3,213	1.1%
Elmhurst	4,182	4,136	195,745	12,168	233,110	(3,193)	8,974	2.2%
Harlem	2,914	2,921	113,604	(1,022)	165,078	(455)	(1,477)	-0.5%
Jacobi	3,969	3,835	196,607	10,223	253,690	(265)	9,958	2.3%
Kings County	5,091	5,022	223,063	6,982	288,477	1,679	8,661	1.7%
Lincoln	3,994	3,909	178,359	(7,877)	210,171	3,487	(4,390)	-1.1%
Metropolitan	2,463	2,429	96,337	(1,836)	135,414	1,099	(737)	-0.3%
North Central Bronx	1,351	1,338	55,456	528	80,694	(1,271)	(743)	-0.6%
Queens	2,795	2,771	118,686	5,767	147,947	2,627	8,393	3.2%
Woodhull	2,853	2,805	122,375	(5,753)	171,617	2,845	(2,908)	-1.0%
Acute Total	38,146	37,577	$ 1,714,603	$ 34,074	$ 2,193,978	$ 889	$ 34,963	0.9%
Gotham								
Belvis DTC	128	125	$ 3,965	$ (489)	$ 6,365	$ (115)	$ (604)	-5.6%
Cumberland DTC	200	197	9,727	(865)	11,493	(205)	(1,071)	-4.9%
East New York	207	202	8,872	(2,163)	8,503	614	(1,549)	-7.7%
Gouverneur DTC **	448	452	20,815	1,836	22,853	103	1,939	4.6%
Morrisania DTC	232	232	8,529	(3,008)	11,059	(151)	(3,159)	-14.1%
Renaissance	166	162	5,336	(25)	7,833	88	64	0.5%
Gotham Total	1,381	1,369	$ 57,245	$ (4,714)	$ 68,106	$ 334	$ (4,380)	-3.4%
Post Acute Care								
Coler	1,077	1,022	$ 35,264	$ 4,580	$ 52,476	$ (1,332)	$ 3,248	4.0%
Gouverneur SNF **	362	380	13,939	(738)	18,387	1,011	273	0.8%
H.J. Carter	900	857	60,828	5,358	49,631	(1,611)	3,747	3.6%
McKinney	439	428	16,751	(1,334)	18,480	(39)	(1,373)	-3.8%
Seaview	532	513	16,612	(3,124)	22,090	(955)	(4,079)	-10.0%
Post Acute Care Total	3,310	3,199	$ 143,394	$ 4,741	$ 161,065	$ (2,927)	$ 1,814	0.6%
Central Office	1,022	986	331,558	8,184	149,459	3,702	11,886	2.5%
At Home	398	436	25,105	5,775	18,489	(1,475)	4,301	11.8%
Enterprise IT/Epic	1,157	1,201	0	(3)	114,013	4,091	4,087	3.5%
GRAND TOTAL	**45,414**	**44,768**	**$ 2,271,906**	**$ 48,057**	**$ 2,705,109**	**$ 4,614**	**$ 52,671**	**1.1%**

*Actual Global FTEs have dropped by 4,641 since November 2015.
Global Full-Time Equivalents (FTEs) include HHC staff and overtime, hourly, temporary and affiliate FTEs. Enterprise IT includes consultants.
At Home includes HHC Health & Home Care and the Health Home program.
** Gouverneur's receipts were adjusted to reflect appropriate actuals.

NYC Health + Hospitals
Cash Receipts and Disbursements (CRD)
Fiscal Year 2018 vs Fiscal Year 2017 (in 000's)
TOTAL CORPORATION

	Fiscal Year To Date November 2017		
	actual 2018	**actual 2017**	**better / (worse)**
Cash Receipts			
Inpatient			
Medicaid Fee for Service	$ 307,184	$ 271,396	$ 35,789
Medicaid Managed Care	348,310	298,168	50,142
Medicare	196,487	219,098	(22,611)
Medicare Managed Care	132,849	133,860	(1,011)
Other	111,928	99,260	12,668
Total Inpatient	1,096,758	1,021,781	74,977
Outpatient			
Medicaid Fee for Service	75,355	40,020	35,335
Medicaid Managed Care	138,234	144,105	(5,871)
Medicare	31,442	28,359	3,083
Medicare Managed Care	41,223	38,936	2,287
Other	71,402	61,609	9,793
Total Outpatient	357,654	313,028	44,627
Risk Pools	25,251	117,577	(92,326)
Total Patient Care Revenue	1,479,664	1,452,386	27,278
All Other			
Pools	133,367	175,113	(41,747)
DSH / UPL	462,171	878,152	(415,981)
Grants, Intracity, Tax Levy	142,562	111,622	30,939
Appeals & Settlements	15,250	3,732	11,518
Misc / Capital Reimb	38,893	28,491	10,401
Total All Other	792,242	1,197,110	(404,869)
Total Cash Receipts	**$ 2,271,906**	**$ 2,649,496**	**$ (377,591)**
Cash Disbursements			
PS	$ 1,012,625	$ 1,157,009	$ 144,383
Fringe Benefits	424,823	394,229	(30,594)
OTPS	610,049	607,919	(2,130)
City Payments	136,687	-	(136,687)
Affiliation	492,061	471,150	(20,911)
HHC Bonds Debt	28,865	35,201	6,336
Total Cash Disbursements	**$ 2,705,109**	**$ 2,665,508**	**$ (39,603)**
Receipts over/(under) Disbursements	**$ (433,203)**	**$ (16,011)**	**$ (417,192)**

NYC Health + Hospitals
Actual vs Budget Report
Fiscal Year 2018 (in 000's)
TOTAL CORPORATION

	Fiscal Year To Date November 2017		
	actual 2018	**budget 2018**	**better / (worse)**
Cash Receipts			
Inpatient			
Medicaid Fee for Service	$ 307,184	$ 284,699	$ 22,485
Medicaid Managed Care	348,310	314,379	33,931
Medicare	196,487	215,166	(18,678)
Medicare Managed Care	132,849	138,507	(5,658)
Other	111,928	104,019	7,908
Total Inpatient	1,096,758	1,056,771	39,988
Outpatient			
Medicaid Fee for Service	75,355	60,491	14,864
Medicaid Managed Care	138,234	154,995	(16,761)
Medicare	31,442	34,837	(3,395)
Medicare Managed Care	41,223	41,623	(401)
Other	71,402	64,188	7,214
Total Outpatient	357,654	356,133	1,521
Risk Pools	25,251	24,406	845
Total Patient Care Revenue	1,479,664	1,437,310	42,354
All Other			
Pools	133,367	137,233	(3,866)
DSH / UPL	462,171	461,687	484
Grants, Intracity, Tax Levy	142,562	142,669	(107)
Appeals & Settlements	15,250	5,204	10,046
Misc / Capital Reimb	38,893	39,746	(854)
Total All Other	792,242	786,539	5,703
Total Cash Receipts	**$ 2,271,906**	**$ 2,223,849**	**$ 48,057**
Cash Disbursements			
PS	$ 1,012,625	$ 1,020,583	$ 7,958
Fringe Benefits	424,823	428,312	3,489
OTPS	610,049	601,582	(8,467)
City Payments	136,687	136,682	(4)
Affiliation	492,061	492,061	0
HHC Bonds Debt	28,865	30,503	1,638
Total Cash Disbursements	**$ 2,705,109**	**$ 2,709,723**	**$ 4,614**
Receipts over/(under) Disbursements	**$ (433,203)**	**$ (485,874)**	**$ 52,671**

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "System") to negotiate and execute a contract with Public Financial Management, Inc. ("PFM") to provide financial advisory and other business consulting services for an amount not-to-exceed $170,000 per annum for a three year term, with two, one-year renewal options, solely exercisable by the System.

WHEREAS, the System currently finances major construction and renovation capital projects, ongoing capital improvements, and major movable equipment through funds received from the proceeds of tax-exempt bonds and leases issued by the System or by other issuers on behalf of the System; and

WHEREAS, the System's involvement in the financial markets through bond issues, capital leases and investments necessitates the use of a financial advisor to review and pursue all financing options available to the System; and

WHEREAS, through a Request for Proposals process for financial advisory services, a selection committee determined that Public Financial Management, Inc. is best qualified to provide the financial advisory services required; and

WHEREAS, the overall management of this contract will be under the direction of the Senior Vice President/CFO, Finance and Assistant Vice President, Debt Finance and Corporate Reimbursement Services.

NOW THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation be and hereby is authorized to negotiate and execute a contract with Public Financial Management, Inc. to provide financial advisory and other business consulting services for an amount not-to-exceed $170,000 per annum for a three year term, with two, one-year renewal options, solely exercisable by the System.

EXECUTIVE SUMMARY

Public Financial Management, Inc.
Financial Advisory Services

BACKGROUND: Per OP 40-58, the System seeks authorization to negotiate and execute a contract with Public Financial Management, Inc. ("PFM") to serve as the System's financial advisor for a period of three years, with two additional one-year renewal options exercisable solely by the System. The total cost of the contract shall not exceed $170,000 per annum.

NEED: The System funds the majority of its capital expenditures with the proceeds of bonds, notes, leases, or other publicly traded securities issued either by the System or by a third-party such as the City of New York on the System's behalf. This activity has become increasingly diverse in recent years, encompassing fixed and variable rate bond issues, fixed and variable rate equipment leases, lease-leaseback financings and possibly utilizing interest rate derivative products. Therefore, it is in the best interest of the System to retain a professional financial advisory firm with market information access and technical expertise necessary to analyze and recommend the structure, fees and pricing of these transactions, as well as to assist the System in presenting its credit to major credit rating agencies in an attempt to achieve rating upgrades.

TERMS: Due to the increasing diversity of the System's financing program, financial advisory services will often encompasses a broad set of assignments. Examples of services provided by a financial advisor include, but are not limited to:

- Assisting in all aspects of the development and implementation of the System's seasonal financing, equipment financing, and capital financing programs;
- Preparing financial and financing analyses and marketing advice in connection with current and future financing plans;
- Analyzing fees, pricing, and other business terms of lease and bond issue transactions, and supporting the System in negotiating such transactions;
- Monitoring federal, New York State and New York City municipal finance policies;
- Tracking yield, market conditions, and rating agency information; and
- Providing special business consulting services on an as-needed basis.

PROCUREMENT: PFM submitted a proposal during the RFP process to provide financial advisory services. PFM was selected by the RFP Evaluation Committee comprised of representatives from the New York City Office of Management and Budget, New York City Office of the Comptroller, the Corporation's Finance staff and a hospital's senior staff. Selection criteria included: overall experience and accomplishments in financial advisory services in public finance and/or healthcare; understanding of the Corporation's credit; responsiveness, quality and content of the proposal; cost proposal and fee structure. PFM has been providing financial advisory services to the System since April 2002.

NYC HEALTH+ HOSPITALS

Short Term Capital Financing

Quarterly Status Report to the Finance Committee

January 11, 2018

Short Term Financing Program

- Through resolutions approved in July 2013, April 2015 and September 2015, the NYC Health + Hospitals Board authorized equipment and other short term financing of up to $120 million, with the goal of allowing the system to establish a flexible short term financing program with “as needed” access to capital funds from one or more banks over multiple years.

- After development of a secondary Health Care Reimbursement Revenue lien security, a JP Morgan Chase financing for up to $60 million worth of primarily equipment purchases closed on July 9, 2015. This loan was converted to a Fixed Rate mode on August 1, 2017.

- A Citibank revolving loan for up to $60 million for mostly routine renovation and IT projects closed on October 14, 2015. This was replaced on November 1, 2017 with a $30 million Fixed Rate loan and a $30 million Variable Rate loan.

2015 JP Morgan Chase Loan ($millions)

Date	Activity/Action	Remaining Loan Capacity	Borrowed Funds
07/09/2015	Authorized to Borrow	60.000	0.000
07/09/2015	Initial Drawdown: Borrowed Amount	(10.000)	10.000
07/31/2017	Final Drawdown: Borrowed Amount	(50.000)	50.000
08/01/2017	Converted to Fixed Rate @ **2.0880%**		
Total		**0.000**	**60.000**
Vouched Capital Expenses as of January 2, 2018			**(57.836)**
Cost of Issuance			(0.128)
Vouched Funds			**(57.964)**

Encumbrances as of January 2, 2018	**59.366**

- Terms: $60 million outstanding loan converted to fixed rate @ 2.0880% with final maturity date of July 1, 2022
- Interest Rates: Avg. variable rate during drawdown period (to 8/1/17): 1.1687%. Prior to converting to fixed rate, the variable rate was 1.6270%

2015 JP Morgan Chase Loan ($millions)

Date	Activity/Action	Remaining Loan Capacity	Borrowed Funds
10/14/2015	Authorized to Borrow	60.000	0.000
10/14/2015	Initial Drawdown: Borrowed Amount	(10.000)	10.000
11/01/2017	Re-Financed and replaced by a loan agreement on November 1, 2017		(10.000)
Total		**0**	**0**
Cost of Issuance			(0.106)

- Terms: Variable rate revolving loan indexed to SIFMA, with a maturity date of October 14, 2018
- Interest Rate: Average rate during drawdown period (to 11/1/17): 1.2740%
  Final variable rate was 1.67% reset on 10/26/17.

2017 Citibank Replacement Loan

- Fixed Rate Loan
  - Borrowed $30 million
  - Repaid the outstanding $10 million 2015 Citi Loan, financed CRA-eligible capital needs and cover cost of issuance
  - 5 year maturity, due on 11/1/2022
  - 2.17%*(based on 5-yr MMD)*

- Variable Rate Loan (available to be borrowed)
  - Up to $30 million
  - 1 year Availability Period, expires 10/31/2018
  - 5 year maturity from each drawdown
  - 1.52% indicative rate as of 11/8/17*(tied to weekly SIFMA index)*

- Replacement Loan Closed on November 1, 2017

2017 Citibank Replacement Loan ($millions)

Date	Activity/Action	Remaining Loan Capacity	Borrowed Funds
11/01/2017	Authorized to Borrow	60.000	0.000
11/01/2015	Initial Loan Drawdown* (Borrowed $30 mill at a Fixed Rate of 2.17%)**	(30.000)	30.000
Total		**30.000**	**30.000**
Vouched Capital Expenses as of January 2, 2018			(40.616)
Cost of Issuance			(0.250)
Vouched Funds			**(40.866)**

Encumbrances as of January 2, 2018	**46.616**

* $10 million was used to repay the 2015 Citibank Revolving Loan on 11/1/17

- ** Terms 2.17% 5-year fixed rate loan, due on Nov 1, 2022

Project Stream: Revenue Cycle Optimization

January 11, 2018

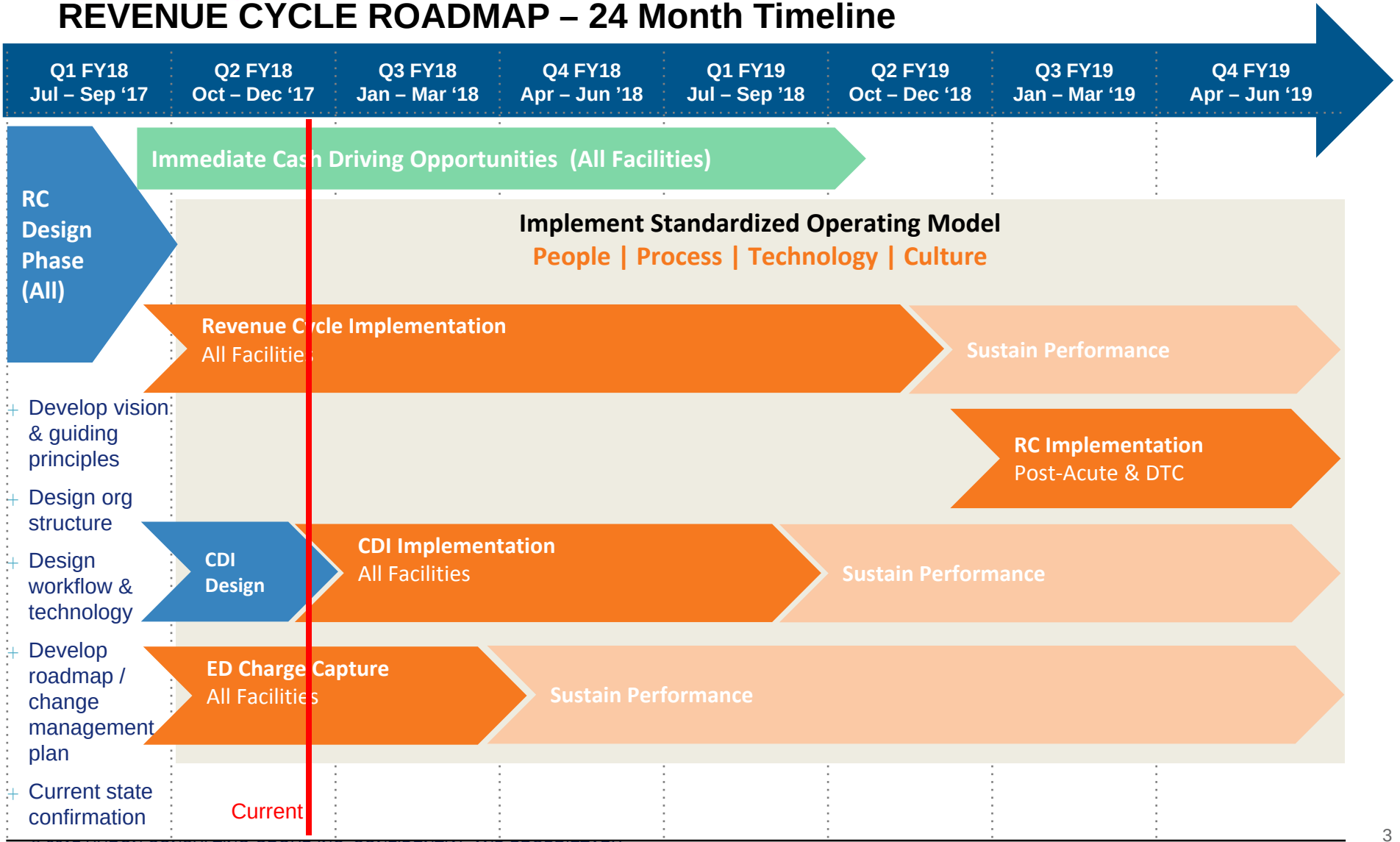
ASSESSMENT FINDINGS

FINANCIAL OPPORTUNITY SOURCES

Financial Opportunity Sources		
Key Benefit Source	**Low Opportunity**	**High Opportunity**
Recurring Revenue Cycle Improvement + Reduction in administrative and bad debt write-offs + Reduction in A/R write-offs through cleanup of unworked populations + Decreased aged receivable leading to avoidable write-offs + Solidified charge capture processes	**$90 million**	**$210 million**
Recurring Clinical Documentation Improvement (CDI) + Increased accuracy/thoroughness of clinical documentation + Increased representation of patient acuity and quality	**$40 million**	**$80 million**
NYC Health + Hospitals Total Annual, Recurring Benefit	**$130 million to $290 million**	
One-Time Cash Flow Opportunity + Reduction in billing backlogs + Reduction in 90+ Days from Discharge/Service (DFD/S) agings + Improved denials management and resolution processes	**$30 million**	**$50 million**
NYC Health + Hospitals Total One-Time Cash Flow Benefit	**$30 million to $50 million**	

IMPLEMENTATION TIMELINE

REVENUE CYCLE ROADMAP – 24 Month Timeline



SUMMARY OF PROGRESS

Assessment (Jun – Jul '17)	Design (Aug – Oct '17)	Implementation (Oct '17 – Ongoing)	Wave 1 Go Live (Nov – Dec '17)
• Completed interviews with facility and central office leadership • Analyzed write-off and denials data to identify opportunities for recurring benefit • Completed chart reviews and analysis on DRG opportunity to identify areas of benefit • Analyzed outpatient E&M distributions against best practice benchmarks	• Developed leading practice revenue cycle design with NYCH+H representation across all facilities • Recommended updated organizational structure for Revenue Cycle and CDI, including hiring of additional positions • Completed staffing analyses to identify necessary staff levels for Revenue Cycle and CDI • Developed new staff alignment strategy and worked with labor relations to approve changes • Designed process to drive consistency across facilities (e.g., meeting structure, documentation) • Obtained and validated data extracts from existing systems to drive Huron technology • Received approval for new E&M criteria from ED Committee	• Implemented immediate cash driving initiatives to drive accelerated financial performance • Provided revenue cycle staff training and materials to focus staff on leading practices • Completed CDI classroom training and over 500 hours of one-on-one mentoring with CDI specialists • Submitted system revisions to QuadraMed to streamline infusion documentation process • Held ongoing meetings with Epic GO team to ensure coordination through Epic design	• Live with the Huron CDI Tool at 11 acute facilities in November '17 • Live with Huron RC Workflow at Bellevue, Kings County, and Lincoln in December '17 • Rolled out daily management reporting to management • Completed Continuous Quality Improvement to ensure all steps have been taken to financially secure an account

OVERALL REVENUE CYCLE UPDATE

Design Phase: Aug '17 – Oct '17

Project Kick-off & Communication

Successfully kicked off engagement and established project governance model across key system and facility level stakeholders

Design

Completed six weekly interactive design sessions with revenue cycle leadership from across H+H to define enterprise-wide leading revenue cycle practice

Short Term Cash Driving Initiatives

Initiated focused activities to start driving early cash increases across all 11 facilities. Initiatives are short term fixes prior to implementation of formal leading practice processes at each facility.

+ **In House High Dollar Review**
  - Reviewed in-house patients with long lengths of stay or high threshold of charges
  - Took action to ensure front-end financial security of each case that slipped through old process (e.g., identified insurance or obtained authorization)
  - Action taken on 97 accounts (out of 719 reviewed) through the process for potential cash opportunity of $7.4M

+ **Aged A/R, High Risk Review**
  - Reviewed accounts greater than 90 days from discharge with high outstanding balances
  - Took action to resolve issues preventing claims from paying timely (e.g., denials or billing edits)
  - Action taken on 297 accounts (out of 773 reviewed) through the process for potential cash opportunity of $5.9M

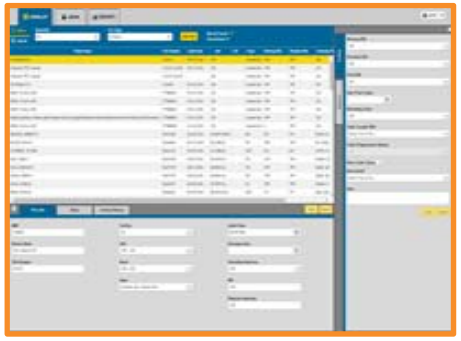
+ **Approaching Timely Filing Review**
  - Reviewed accounts approaching payer contractual filing limits for billing
  - Corrected 1,727 accounts (out of 3,282 reviewed) for a potential cash opportunity of $1M

OVERALL REVENUE CYCLE UPDATE

Implementation Phase: Nov '17 - Current

Wave 1: Facility Implementation

+ Implemented comprehensive revenue cycle changes at the following facilities:
  - Bellevue (12/5/17)
  - Lincoln (12/13/17)
  - Kings (12/13/17)
+ Staff re-organized based on leading practice design to align with job function
+ Updated staff priorities and completed training on new job functions
+ Optimized processes and communication approach
+ Implemented Huron technology, including automated workflow and reporting for the following functions:
  - Insurance Verification
  - Inpatient Financial Counseling
  - Billing
  - Follow-up



CLINICAL DOCUMENTATION IMPROVEMENT (CDI)

The objective of the CDI initiative is to achieve accurate, complete, compliant, and appropriate documentation. Achieving these goal will facilitate appropriate reimbursement, accurate CMI, and improved quality metrics.

People

- Designed a CDI operating model including recommendations to hire a new CDI AVP to provide centralized leadership and work towards system level goals
- Initiated hiring of 37 additional FTEs to cover discharge volumes. Newly hired staff will receive education and training from Huron as they are onboarded.

Education

- Provided classroom training and education for the existing CDI specialists on concurrent documentation review and how to bridge communication gaps between the physician and coding
- Provided over 500 hours of one-on-one mentoring for existing CDI specialists to reinforce the concepts taught in training

Process and Technology

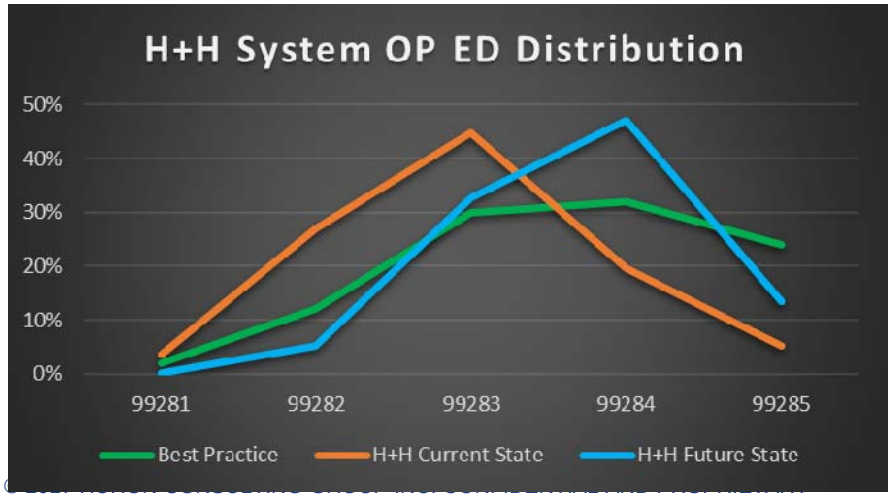
- Implementing process changes to drive consistency across the organization
- Identifying physician advisors at all facilities to improve physician involvement and communication
- Activated Huron CDI Technology at all 11 facilities that include worklists and reporting to drive accountability and track financial benefit

ED CHARGE CAPTURE

The objective of the ED Charge Capture initiative is to improve clinical documentation and charge capture processes to support accurate, timely, and complete reimbursement for ED services performed.

Implementation Progress

- Conducted onsite facility kickoff meetings with all 11 NYC Health and Hospital facilities
- Held ED Charge Capture Committee meetings and approved new facility E&M criteria (pending final approval with H+H Compliance)
- Developed a system enhancement listing to start discussions with IT and Clinical Informatics teams
- Created Epic nursing education documents and submitted for leadership approval (training to begin in Jan '18)
- Next step is implementation of new E&M criteria across the system (Jan ' 18 – Feb '18)

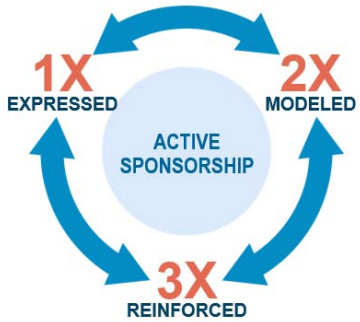


Expected Annual Net Revenue By Financial System	
Unity Facilities	$10M - $16M
Soarian Facilities	$6M - $8M
Total	$16M - $24M

SUSTAINABILITY

To promote long-term sustainability, enhance leadership, and encourage employee solution adoption, we have launched a multi-tiered strategy:

- **Change Management Strategy** – Active sponsorship, expressed/modeled/reinforced behaviors, tools and coaching are incorporated into the implementation approach
- **Accountability Structures** – The table of organization for the revenue cycle will be transformed, including changing reporting relationships and adding additional leadership positions to promote accountability
- **Workdrivers and Reporting** – Workdrivers and processes have been designed concurrently and in coordination with Epic Financial design. Leading practice revenue cycle approaches are hard-wired into the tools and reinforced with automated reporting
- **Onsite Project Support** – The implementation approach for each facility includes a 2-4 month transition period to provide training, monitor quality, and ensure new processes are properly understood and adopted. Additionally, Huron resources will be on the ground at H+H implementing through the summer of 2019.



NEXT STEPS

- Bellevue, Lincoln, Kings – drive improved metric performance in new RC operating model
- Elmhurst – implement comprehensive revenue cycle changes & Huron technology (1/23/18)
- Woodhull, Jacobi, NCB – begin preparations for go-lives in March 2018
- All Facilities
  - Continue immediate cash driving and performance improvement initiatives
  - Hire for the open revenue cycle and CDI positions
  - Begin to measure financial improvements
  - Obtain approval and implement new E&M criteria for ED Charge Capture
  - System-wide Huron revenue cycle reporting – targeting Feb/Mar 2018