



FINANCE COMMITTEE AGENDA

Date: December 5, 2022
Time: 12:00 P.M.
Location: 50 Water Street, 17th Floor, Boardroom – In Person

I. Call to Order

Adoption of the October 17, 2022 Minutes

Freda Wang

II. Financial Update

John Ulberg

III. Old Business

Freda Wang

IV. New Business

V. Adjournment

Finance Committee MEETING - October 17, 2022

As Reported By: Freda Wang

Committee Members Present: Freda Wang, Mitchell Katz, MD, Sally Hernandez-Piñero, José Pagán, Feniosky Peña-Mora, Barbara Lowe, Patricia Marthone, MD

CALL TO ORDER

Ms. Wang called the meeting of the New York City Health + Hospitals Board of Directors Finance Committee Meeting to order at 1:06 p.m.

Ms. Wang called for a motion to approve the July 11, 2022 minutes of the Finance Committee meeting.

Upon motion made and duly seconded the minutes of the Finance Committee meeting held on July 11, 2022 were adopted.

ACTION ITEM: Medical Respite Operations and Services

Ms. Jontef presented a resolution:

Authorizing New York City Health and Hospitals Corporation (the "System") to sign three-year agreements with each of Institute for Community Living, Inc. ("ICL") and Comunilife, Inc. ("Comunilife") for the provision by ICL of 26 respite beds and by Comunilife of 25 such beds with the System holding two 1-year options to renew both contracts for an amount for the two contracts together not-to-exceed \$17,960,500 over the potential five-year terms.

Ms. Jontef began by providing the background of Housing for Health initiative. NYC H+H launched Housing for Health in 2020, with a goal of securing interim and permanent housing options for patients experiencing homelessness. With Over 46,000 H+H patients experiencing homelessness and 22,000 H+H patients also being DHS clients, Medical Respite is one of our strategies to provide transitional to permanent housing for our patients. Other strategies include using our land working with other agencies and in some cases funding social services and permanent housing. Expediting this population into stable housing saves lives, improves health outcomes, and reduces expensive emergency health care and in-patient resources. To date, over 450 patients have been permanently housed and over 800 people have benefited from interim housing at medical respite.

Ms. Momplaisir-Ellis presented the background and current state of Medical Respite Services. Patients experiencing homelessness have greater medical acuity and longer hospital stays. When medically cleared for discharge, they often cannot return to a shelter or street due to their post-surgical, medical and/or behavioral health needs. Medical Respite provides a solution,

an Interim Housing Option with 24/7 staffing that allows clinical providers to come onsite to perform services like: wound care, oxygen, IV Infusion, physical therapy, and home health aide services.

An overview of the model was presented. The model includes services provided primarily by case managers, peer specialists and social workers. Respite staff provide care coordination, support with transport to medical appointments, and linkage with primary care, behavioral health and substance use services. Since the respite operators currently do not provide any direct clinical services, clinical services are provided by various vendors who come onsite. The clinical aftercare services are arranged by NYC H+H facility discharge planners based on patients' clinical needs. The model provides extensive housing case management to support connections to more stable and appropriate housing. The goal of Medical Respite is to stabilize patients' health, provide needed social services and facilitate connections to more stable and appropriate housing. In addition, other goals are to reduce the length of patients' hospital stay and prevent avoidable hospitalization and ED utilization.

Ms. Momplaisir-Ellis continued providing the state of current contracts and current program successes. NYC H+H has managed Medical Respite Services since 2019. One City Health, H+H Population Health and Post-Acute Care teams executed distinct contracts in 2019 and 2020. In 2020, the Housing for Health team began managing and consolidating the respite contracts. In 2021, H+H signed a best interest extension for 51 beds with two CBOs, Institute for Community Living and Comunilife. In 2022, Housing for Health released an RFP to continue providing Medical Respite Operations and Services. The Medical Respite program has been very successful and highlights of the current program outcomes were presented. Lastly, H+H's investment in Medical Respite services is the largest in New York City.

An overview of the program finance cost savings Analysis was presented by Ms. Momplaisir-Ellis. Currently, the average cost of current beds in respite is \$150 per bed per day. A H+H Medical Respite option assures that patients do not remain in our hospital beds when they no longer have an acute care need. Direct variable supply and labor costs of caring for the patient in the hospital are approximately 5 times the cost of respite. The investment in medical respite directly avoided an estimated \$17 million on hospital operating costs. Furthermore, helping appropriate patients transition to respite frees up inpatient beds for patients who truly need acute care. We estimate that respite has opened up access for 950 new patients in our hospitals, translating to an estimated net revenue up to \$16 million.

Ms. Momplaisir-Ellis continued by providing an overview of the procurement process, vendor selection process and RFP criteria. All vendors considered were closely evaluated and proved to have strong experience and qualifications. Both proposals received were from providers currently offering respite services. Performance evaluations were presented. Scoring tabulations were completed and the two highest scores; Institute for Living

and Comunilife were both selected, respectively. The vendor minimum criteria required entities to be non-profit. In terms of MWBE, Non-profit community-based organizations are exempt from the MWBE requirement.

The contract terms were presented and reviewed by Ms. Momplaisir-Ellis. It was noted in this iteration of the contract; more clinical services are put in place and CBOs will have limited access to view and access patients records on Epic.

Ms. Momplaisir-Ellis requested the Finance Committee's approval to award contracts to Institute for Living and Comunilife, for consideration by the Board of Directors.

Ms. Wang polled the committee for questions.

Mr. Siegler commended the team and added that he was fortunate to be part of One City Health at the end of DSRIP and this is an example of H+H's continued investment of its own funds as a continuation of the prior Medicaid Waiver. H+H has now continued this for several years and has the largest respite program in the City, as far as we are aware. The level of commitment from our System to keep those programs going when many other systems ceased when the waiver ended is a great testament to this team and our system's commitment.

Ms. Lowe added, Dr. Rosa Gil has been phenomenal for decades doing this work and I'm glad that she has continued so we could join her as she would have loved this to have occurred many years ago. This is a very good collaboration, and it means a lot and hope others could learn from our experiences.

Mr. Peña-Mora commended the team for the great work and the impact in terms of both patients' care and the ability for the hospital to be able to give care to other patients. He inquired about the funding allocated to this program and the insurance mechanism used to cover the expenses of these patients, asking if it will cover these housing costs or if completely financed through our operating budget as there is no way recover those costs.

Mr. Siegler responded that at this point it is all our operating budget. However, there is a meaningful offset as we pointed out in just the inpatient revenue and the savings at the facility level. There is also, we believe, a meaningful contribution to the risk surplus we generate through our value-based contracts when these patients are in those contracts. We are hopeful that there will be some State reimbursement through Medicaid coming for respite services. There have been policies changes to allow that, but the final regulations are not out. When these do come out, that may be an opportunity for these CBOs to offset some of the costs that they are billing us for, or may open up the potential for even more expansion if we have that kind of steady, very dependable trackable revenue source. As of right

now, we fund this out of our operating revenues or margins for the rest of the system and the offsets in other parts of the budget.

Mr. Peña-Mora added, trying to understanding the logic, in theory if these patients were to stay in the hospital will there be revenues coming at a certain point?

Mr. Siegler confirmed that this is correct at a certain point. However, most of the reimbursement on the inpatient side is episodic and episode based. So, if these individuals are staying in the hospital for 3-5 months, the revenue does not continue to increase at pace with the costs of them being there.

Mr. Peña-Mora commented in terms of the presentation, we have tried to be consistent in terms of both MWBE and the demographics, and in this presentation, it was placed in the appendix. He recommended these to be included as part of the main presentation for consistency.

Ms. Hernandez-Piñero asked in regards to the cost of 17 million dollars.

Ms. Jontef responded, the request to contract is for a three-year extension. The resolution for your consideration is that combined amount and the analysis that finance helped with is a one-year examination.

Ms. Hernandez-Piñero added, so these costs should be divided up. The total contract amount should be divided, correct?

Ms. Jontef elaborated on the analysis. On an annual basis, it is around 2-3 and a half million dollars and change. The analysis is on savings and revenue and was also based on one-year, not for the 815 people.

Mr. Siegler added that we want to continue to track the results as the analysis is sensitive to things like the expected length of stay for the individual and the ability to backfill with additional new patients. Those things have fluctuated pretty significantly over the last couple of years and we do these financial analyses as illustrative and directionally correct, but we need to continue to build them out and supply any updates as these proceeds.

Ms. Lowe provided an anecdote of an instance when patients went to Woodhull, they came deliberately when they were not so well to be able to get in the door and then stay for quite some time because they were homeless. So, there is another hidden cost here if you will. This has a two-pronged impact to it if that person is taking a bed when there are also those who need that bed badly.

Dr. Katz commented on the workforce issues. It is interesting the workforce issues that Dr. Marthone talked about earlier also are intensifying the benefits of this. We cannot even hire more nurses and doctors to take care of patients in the hospital. So, beyond the financial savings that we think there exist, we are literally having trouble with access, so if people move

out of the hospital to an appropriate level, we gain the ability to hospitalized them, which we were trying very hard to keep up with the demand for our services. This is one of the ways that we can help, but it is very discouraging. To connect to Sally's discussion, some insurances would have to continue to pay for the hospital bed but are not required to pay for the rest of, as it is not a covered service. It is very complex as for example, if it is Medicare you are getting one payment for the whole hospitalization regardless of how long that person stays, so you are going to save a lot of money by putting them here. If it is Medicaid and you are getting a non-value-based Medicaid, then probably it is not such a great financial deal as Medicaid is paying every day for the day but they are not going to pay for this. However, if it is value-based it is probably okay as they figure in what Healthfirst and MetroPlus are and what our costs are in determining how much money we get at the end of the year.

Getting back to the earlier point that all of the actual financials you can only project using estimates of what you think the mix will be of patients going into it and how that space will be used. The good thing is that prospectively which is what Matt referred to, you can calculate an actual number. For each person that actually moves in, they will tell you in real time but again it is all subject to change and who you put in. We have always tried to do as discussed before, to never consider insurance status as part of care. On the other hand, arguably we are caring for them either way, so maybe here it is acceptable to consider who is paying as we will take care of them either way but maybe it is more financially advantageous for value-based patients to move but it is really, the basic framework it is all wrong. The basic framework should be to take care of people in the right setting, especially if it is less expensive. The current system it is so messed up, that makes it very hard to do what seems like such a straightforward concept. We will take care of everybody in the best setting possible, considering the use of the resources.

Ms. Wang added that we are currently doing so Mitch. The fact that we are moving the patients over even if maybe we could get reimbursed if they stayed in the hospital, seems like the right thing to be doing. And from a financial impact, what we are seeing is that it is dependable on a case by case scenario and whether it is an economic decision that was good or bad, but it certainly freed up beds. We have occupancy rates that are very high in our hospital and so presumably we are getting other patients in that are now generating revenue. This is an attempt to try to do the right thing.

Dr. Katz added that we are trying and it is the rest of the world that is not trying. If the rest would try, we would be able to do better too. We could create many more such beds because the demand is there, but we are limited by the fact that we have to put general funds to this recognizing that even though a large number of these patients are hospitalized, and arguably because the uninsured would still be emergency Medicaid. We are always getting some payments when they are in the hospital. In order to do

what is right, we are paying out of pocket instead of the people who are insuring patients and that is what is wrong.

Ms. Hernandez-Piñero added that we are able to get 6,674 referrals for 50 beds.

Dr. Marthone commented that it is almost like we have our own merch, we have our own redesign team. Not to sound too optimistic but makes you wonder how much convincing the modeling that we are doing can convince the rest of the State to follow. And we have a big enough pool of patients to generate the data that it might be worth both our time and their time to see the outcome, see this through at least for another season or two to see where this goes and to see what we can produce and how much savings it would cost in the end. We are not talking about gerrymandering care, because we are not about that, we are about care first. We are talking about what is more practical in terms of the pay per day and let's figure that out. She is for supporting this to see if we can make things work and maybe change the country's mind about how we are doing it.

Ms. Lowe added that a fair amount of marketing is necessary. There are folks who could have gotten more involved and they are very much stigmatizing the population and that is a real issue. We can do a very good job at marketing the benefits of this.

Ms. Wang inquired in regards to the 35% of patients into housing for respite, which is amazing, but would we have been able to do this moving them from the hospital?

Ms. Jontef responded that it would be too difficult. Trying to find housing would take too long as well as the amount of paperwork required to access the housing that these patients would thrive in is quite laborious and so it is impossible to do it in a month or two if you are in the hospital, you have a little bit more freedom of flexibility if you are at respite, you are recovering and then you can start pulling together all the documents. Also, social workers are quite busy and overwhelmed in an in-patient setting. Having this happen offsite is better.

Ms. Wang added, so all these other benefits as well that are not necessarily quantifiable in the same way.

Ms. Hernandez-Piñero inquired regarding respite care being funded. Comunilife were subsidized to create these rest of the facilities, right? The ability to increase the number of units, and the pipeline coming down.

Ms. Jontef responded as of now these two providers are operating 51 beds. We opened up the RFP. We were hoping more people would come on and get another 20 on top of it. As no new providers came onboard, we continued with these providers who were exceeding expectations and satisfactory performers.

Mr. Siegler added it is a pipeline question you are asking Sally. We are thinking a lot about it, if the state coming with regulations to potentially pay for this on one level it is quite positive. But if the regulations essentially regulate respite like a hospital bed, the economics do not work and the pipeline of building new of these will become quite too difficult. We will ultimately look at whether we want to build some of our own and if we want to repurpose some space to do this, but a lot is hanging in the balance of what do the regulations say and how much like a hospital do regulators try to make these respite settings and there is a trade-off of doing it.

Ms. Lowe added the respite is not the last housing issues for these individuals. There is a bit of a movement now to try to get people into public housing. More is being done and there is a lot of noise going on that would support people being transitioned into their homes. Once they are stabilized and managing well they should be able to get priority at some of the public housing.

Mr. Pagán asked whether there is a way to signal how much of this is needed within the next couple of years? Part of the issue is these organizations are taking the risk now, right? They are saying we put a building, this number of rooms or beds are set up for this and they need to have a sense of like should I double this, triple it. As it takes them a few years to basically set it up.

Ms. Jontef responded in NYC no one is building this. They leverage if someone has it underutilized, or seems to have a relationship with a landlord. In other parts of the country maybe, someone may consider a new construction in another building. In terms of ICL and Comunilife, these contracts are small enough and the term is very finite that they can separate those contracts. That makes it less risky as no one is building new buildings, no one is relying on us to pay that service of a new building. It is just utilizing space that is underutilized.

Following the discussion and upon motion made and duly seconded, the Committee unanimously approved the resolution for consideration by the Board.

FINANCIAL UPDATE

Mr. Ulberg opened the presentation with the FY-22 Year-End highlights. He conveyed that we closed the year with \$700M (28 days cash-on-hand). The budget broke even and closed June with a positive Net Budget Variance of \$29.7M.

Mr. Ulberg continued, stating that direct patient care receipts came in \$617.4M higher than the same period in FY-21 with patient volume coming back, our revenue initiatives maintenance of effort and UPL conversion coming through patient care.

Patient care volume is returning to pre-COVID levels in FY-22, and is 1% ahead of FY-20 in discharges. Revenue base remains strong and resilient primarily driven by returning volume and higher average collectability rate. Overall, our strategic financial initiatives exceeded our fiscal year target of \$614M. Several areas of strong net performance were noted.

Mr. Cassidy presented the cash projections for FY-23. The System closed August with approximately \$600 million (25 days cash-on-hand) and expects to close September with approximately \$550 million (23 days cash-on-hand). In addition, we continue to work closely with the City on our remaining liabilities due to them as we continue to closely monitor our cash position in relation to any ongoing uncertainty around COVID-19.

Mr. Ulberg presented the external risks. Current inflationary costs and wage pressures present a challenge to recruitment and staffing. Health and Hospitals is diligently working to address this and continues to develop its staffing models to meet industry standard. Temp Agency Nursing Costs continue to present a financial challenge due to higher agency rates and the need to rely on agency temps as we recruit full time nurses. The NY State Mandated Staffing Committee work may present us with additional staffing needs with associated financial needs. Lastly, MetroPlus predicts a reduction in attribution as a result of the Medicaid Recertification.

Ms. Tyler presented the financial performance highlights for FY-22 thru June Net Budget Variance. She noted that June ended with a net budget variance of \$29.7M (0%). Receipts exceeded budget by \$660M Primarily driven by Patient Care Revenue. While Inpatient and Outpatient volume and average collectability rates are higher than budgeted, Risk is higher due to Medicaid enrollment exceeding target, and MetroPlus payments on behalf of prior years. Disbursement exceeded budget by \$630M, which includes expenses associated with COVID, and Temp coverage costs.

Ms. Tyler continued providing FY-22 thru June performance drivers updates. Cash receipts are 7% ahead of budget as patient volume returns at a higher percentage than anticipated, and as H+H meets and exceeds planned strategic service line improvement, managed care contract performance, and revenue cycle initiatives. Risk performance exceeding target is also a contributing factor. FY-22 thru June, cash disbursements are over budget by 7% primarily resulting from unbudgeted COVID and Temp spending and Agency costs exceeding target.

Ms. Karlin presented the FY-22 Revenue Cycle achievements. A reduction in primary denial rate by 6%, which was a huge percentage reduction. Increased cash posting by \$457M (10%) compared to FY-21. The improvement of the overall financial counseling rate from 79% to 89%, generating a cumulative \$154M. Clinical Documentation Improvement (CDI) generated \$89M in benefit; Clinical Documentation Secondary Review generated \$35M. Deployed 13 New Instructor-led Training Modules and 5,265 individuals participated in training delivered by Revenue Cycle Institute. Lastly, Revenue Cycle

implemented all requirements of No Surprises Act including 100% automation of Patient Good Faith Estimates. Looking ahead, the goals are to reduce primary denial rate to Epic to the top 25%, leverage additional Epic functionality to improve patient financial experience and Lastly, to improve timeliness of charge capture.

Ms. Hartmann presented an overview of FY-22 Financial Counseling Screening Rates and Revenue Cycle's efforts for enrolling eligible uninsured patients. In FY-22 Financial Counseling Screening rate increased to 90%. An overview of the uninsured patients Financial Assistance metrics were provided. For Patients screened within 72 hours of discharge from Emergency Department 71% were successfully enrolled. Outpatient scheduled population and the percentage being screened prior to service 32% were enrolled. Additional enrollment opportunities were highlighted. Efforts to continue to optimize screening rates and conversion of screenings into health insurance enrollment. Assisting patients with maintaining continuous coverage through proactive outreach to NYC Care members and Medicaid recipients. Optimize timing of screenings for best patient financial experience. Looking to Pilot a "One Stop Model" for public benefits beginning with SNAP enrollment assistance and targeted initiatives with special population. FY-23 targets continued to be evaluated.

Mr. Ulberg added on this presentation. The 32% enrollment for the outpatient screening prior to service, provides an area of opportunity for improvement. We will study where that is and why is occurring. For these patients, there is opportunity for securing insurance, as well as help them with other services that they may qualify for and do not get the proper access. This is an area of opportunity worth exploring.

Ms. Tyler provided a walkthrough the FY-23 Preliminary Highlights. FY-23 YTD August Inpatient volume is 3.7% higher than FY-22, and is within 1% of reaching Pre-COVID levels. Outpatient non-testing volume is up 2% from prior year and is exceeding Pre-COVID levels by 4%. IP and OP cash is down 3% compared to prior year due to RBG bill holds post name change from Coney Island. When excluding RBG, IP/OP cash receipts are up 3% (\$20.7M). MetroPlus and Healthfirst Enrollment is up 8% compared to the same period last year and 2% ahead of the budget target.

Ms. Farag presented the High Impact areas at the start of FY-23 including Nursing Costs. Temp agency higher rates and need to rely on agency temps as we recruit, continue to present a financial challenge. Continuing at the current level of temp utilization in IP and ED, for example, can result in a significant overspend of the annual budget. As we transition away from COVID surge to regular operations, staff nurses are needed in many areas to manage our returning patient volume as we recruit full time nurses towards modeled staff nurse levels in IP and ED areas. Nurses are also needed to meet the demand in the OR and BH areas as we roll-out those models.

Ms. Lowe commented in regards to the nursing costs. Being a nurse, nursing has become a revolving door unfortunately. We work with universities and student nurses and can work to spice up their offers. There is an opportunity and a number of initiatives to help nurses stay here with us for a while. There are nurses who pulled out their licenses during this period because there was a big bonus financially.

Mr. Ulberg added, we will work on that balance between our own nurses and temp nurses.

Mr. Siegler presented the Value Based Payment Performance Key Drivers of Success updates. H+H drives success in Value Based Payment via three key strategies. These are Growing attributed membership, Growing Risk Surplus and Improve quality of care and boost quality bonus payments. H+H is making progress in all three domains. Membership is up over 110k since January 2020 due to pause in Medicaid recertifications. H+H is building out a new workflow within patient registration to outreach to Medicaid members needing to recertify at the close of the Public Health Emergency. ACO generated shared savings for 9th consecutive year - one of only 11 nationwide to achieve this. Implementing an outpatient risk adjustment coding tool to support physicians with this work; currently live in Adult Primary Care and piloted within Peds and Express Care. MetroPlus preliminary 2021 qualify results are promising: NYC H+H outperformed rest of provider network on 11 of 14 measures. On measures where H+H was top performer, on average results were 12% better than the network. Strong results in this area.

Mr. Siegler continued by providing an update on Managed Care Contracting. Since September 2021, H+H has added 10 new insurance plans to network and completed 15 contracts renegotiations. As of October 1st, H+H is in network with Cigna. There is continued progress on contract negotiations and settlements with Emblem. Extended United Behavioral Health agreement for three years. Managed care rate increases and settlements brought in \$212M in new revenue in FY-22 up \$70M compared to FY-21.

Ms. Jones commenced the presentation by noting the rebranding and providing the status on the Test and Treat Corp. H+H incurred \$1.32B of expenses in FY22. Revenue included CDC ELC grants, FEMA funding, and ARP funding. H+H received over \$150M of billing revenue at T2 testing sites. OMB has provided H+H with sufficient revenue through the T2 MOU to cover FY-22 committed expenses.

Ms. Wang polled the committee for questions.

Mr. Peña-Mora requested clarification on the FY-23 Cash Projections presentation. He inquired regarding the cash in hand metrics. Is there a quarter where we are lower or higher and can you show the trends over the last years cash in hand?

Mr. Ulberg responded, that is a great question. It is one which we put in front of the State. Desensitize them to that volatility. When we present

25 days cash on hand, that is not a lot of money and the national average for most hospitals is at least 10 times that amount.

Dr. Katz added, the State defines it as 90 days.

Mr. Ulberg continued, we tried to press with our partners at CMS the importance of having continuous flow of funds and we discuss DSH and they come in big lump sums. We can try to manage that. We would rather have those dollars actually get in and put it into the rates. This comes to us every single time, we provide a service and 20% of our funding comes from these supplemental sources. To the extent that we can embed those into the fees that we get paid, we will be far better off and it is another reason why we like Value based payments as it comes into the risk pool and we can manage it. It is more continuous, predictable stream. The volatility of that is we get down to 10 days, sometimes as high as 40 days. Again, we are just trying to smooth that out but 25 days. These are part of some of the discussions we would like to have with CMS.

Mr. Peña-Mora continued, that was the key question. He would like a demonstration for a very similar amount in the year. As I noticed a different presentation with another measure, accounts receivables at 47 days or 45 days, there is a gap between those two measures.

Dr. Katz commented that part of how James has to do this is to control how we pay the bills. So, the volatility would be much, much greater if it weren't the great work that James and his team has to do. We cannot pay bills as they come. The days are much flatter than the actual revenues coming in.

Mr. Pena-Mora inquired regarding the three measurements, how much do we want to get into the details for accounts receivables and accounts payable.

Ms. Wang commented it is complicated by the relationship with the city.

Mr. Ulberg added we are trying to elevate that to the State and the Feds, we are trying to do that especially as it relates to the supplemental payments. We would rather pay all our vendors as it would help us get better prices at the end but it is this predicament that we really are trying to start with the State. We have conversations with CMS, we live off those supplemental payments, but to the extent that we can increase them at the same time, we make them steadier. We would be better off financially.

Ms. Hernandez-Piñero asked in regards to united behavioral health agreement meaning.

Mr. Siegler responded that United HealthCare subcontracts as many health insurances, their behavioral health services to a vendor called united behavioral healthcare for the medical benefits. We renegotiate our contract with them to improve our rates and terms.

Mr. Ulberg commented on the previous conversation. Hitting the facility DSH cap, under federal rule, you cannot draw in more depth than to cover your costs for serving the uninsured and Medicaid. That is slightly unfair. To only be able to make your costs and should not be safety net system that is 75% Medicaid noninsured be able to earn some sort of margin off of that. And that would help financially too. That would have to change at the federal level with an act of congress.

Ms. Wang inquired regarding the value-based care, does that help us avoid some of this or does not count.

Mr. Ulberg responded to the extent that we get dollars that we earn through quality pools, those do not count in the facility DSH cap. To the extent that we can earn money through the ACO mechanism that does not count. There are things we would like to explore with the government. That is why we preferred value-based payment to the extent that you are rewarded and make margin based on meeting quality objectives, that seems like a pretty good model to us and one that we should be rewarded for. It has been part of our plan to hit the DSH cap as it will open other opportunities for us and fill in gaps and discuss further with you as we develop our agenda.

Ms. Wang commented we should do an informational session on cash flow.

Mr. Peña-Mora added he would really appreciate it as he would like to learn more.

Mr. Peña-Mora and Ms. Wang thanked the team.

ADJOURNMENT

There being no further business before this committee, the meeting adjourned at 2:06 PM.







NYC Health + Hospitals
Finance Committee Meeting
December 5, 2022



FY23 Quarter 1 Highlights

- The system closed September with approximately **\$550 Million (24 days cash-on-hand)**.
- Closed Q1 with a **positive Net Budget Variance of \$46.5M (1%)**
- Direct Patient Care Receipts (I/P and O/P) came in **\$10.8M lower than the same period in FY22** with largely attributable to billing holds at South Brooklyn post name change. There was also a \$28M MetroPlus UPL overpayment in Q4 of FY22. This is partially offset by \$21M in UPL conversion earned through the rates in FY23 Q1.
- Patient care **volume** in FY23 is **returning to pre-COVID levels**, and is 1% behind FY20 in discharges and 3% ahead in OP visits. Revenue base remains strong and resilient primarily driven by returning volume and higher average collectability rate.

- The system is estimated to close November with approximately \$400 million (17 days cash-on-hand).
- We continue to work closely with the City on our remaining liabilities due to them as we continue to closely monitor our cash position in relation to any ongoing uncertainty around patient volume and COVID-19.

Risk	Status
<p>Wage Pressures & Related Costs</p> <p>(Wage pressures and competing for a shrinking workforce is presenting challenges to recruitment and retention of staff, which we are working on addressing.)</p>	
<p>Temp Nursing Costs/NYSNA Committee Recommendation</p> <p>(Temp agency nursing costs continue to present a financial challenge due to higher agency rates and the need to rely on agency temps as we recruit full time nurses. The NY State Mandated Staffing Committee work may present additional staffing needs with associated financial needs.)</p>	
<p>Medicaid Recertification</p> <p>(MetroPlus predicts a reduction in attribution as a result of the recertification.)</p>	
<p>State/H+H/City Medicaid Initiatives</p> <p>(Continue to work with CMS and NYS to finalize 2020 and 2021 Inpatient and Outpatient fee-for-service UPL payments owed to H+H. Working with the state on developing programs for targeted investments in behavioral health services and care management for special populations starting with homeless single adults.)</p>	



Financial Performance

FY 2023 September YTD



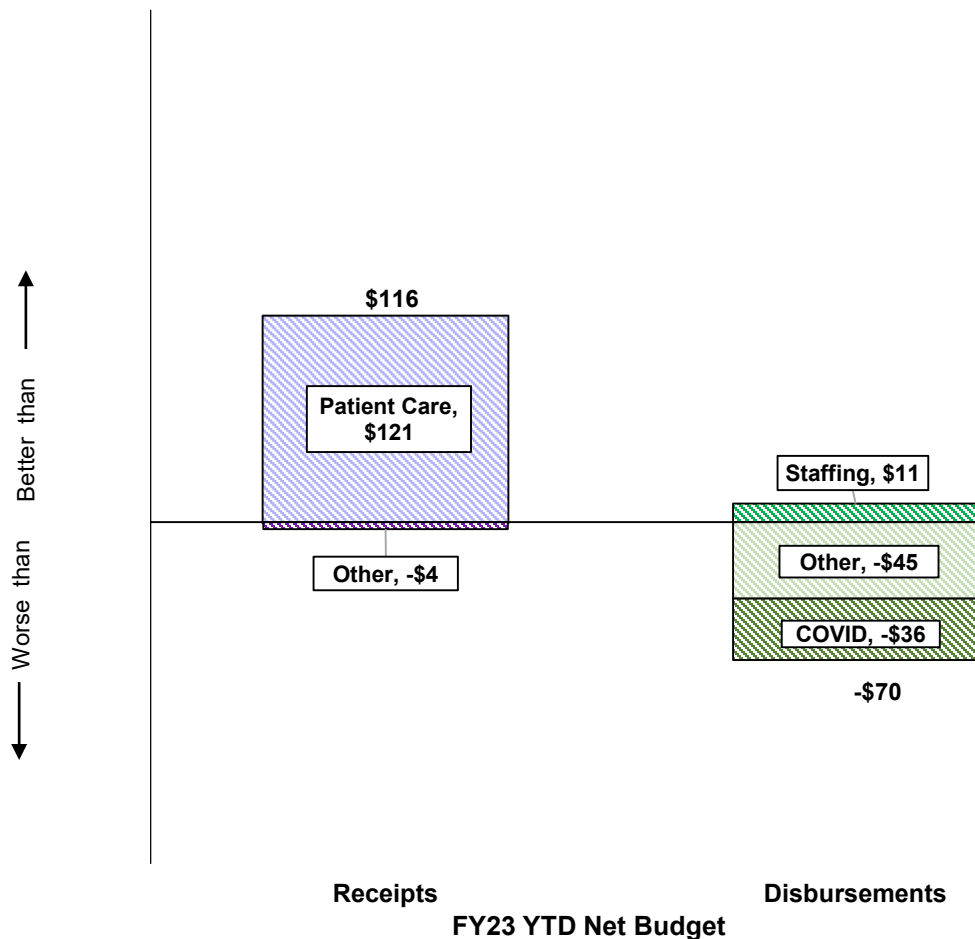
FY23 thru September

Net Budget Variance

Highlights

Ended September with a net budget variance of \$46.6M 1% where

- Receipts exceed budget by \$116M Primarily driven by Patient Care Risk Revenue. Risk is higher due to MetroPlus payment on behalf of prior year and improved PMPM.
- Disbursements exceed budget by \$70M, which includes expenses associated with COVID, and Temp coverage costs.



Notes:

- Test and Trace not included in the Net Budget Variance.

Cash receipts are 6% ahead of budget. Majority of the overage can be attributed to Risk revenue exceeding target due to prior year earnings, and higher than anticipated PMPM.

- IP rates, volume, and PACS performance \$(24.8M) - IP discharges are 1% below budget target, losses offset by improved rates. PACS cash higher than target due to delay in prior year billing hitting in current year and retro rate adjustments for higher CMI.
- MetroPlus PY Overpayment (-\$28M) – One time takeback as a result of PY overpayment in Q4 of FY22.
- Risk Pool Performance and Timing (\$109.4M) - ahead of budgeted target by 140% due to unbudgeted PY reconciliations being collected this year. CY22 Risk PMPM performance coming in better than planned.
- OP Cash and Other Revenue - Cash Collections (\$10.3M) - Physician Billing is higher than budgeted.

Summary Receipts Performance (FY23 thru Sept)	YTD Variance against Budget (\$M)
IP Rates, Volume and PACS Performance	\$24.8
MetroPlus PY Overpayment	(\$28.1)
Risk Pool	\$109.4
OP Cash and Other Revenue (340B, Grants, App/Set)	\$10.3
Grand Total	\$116.4[+6%]

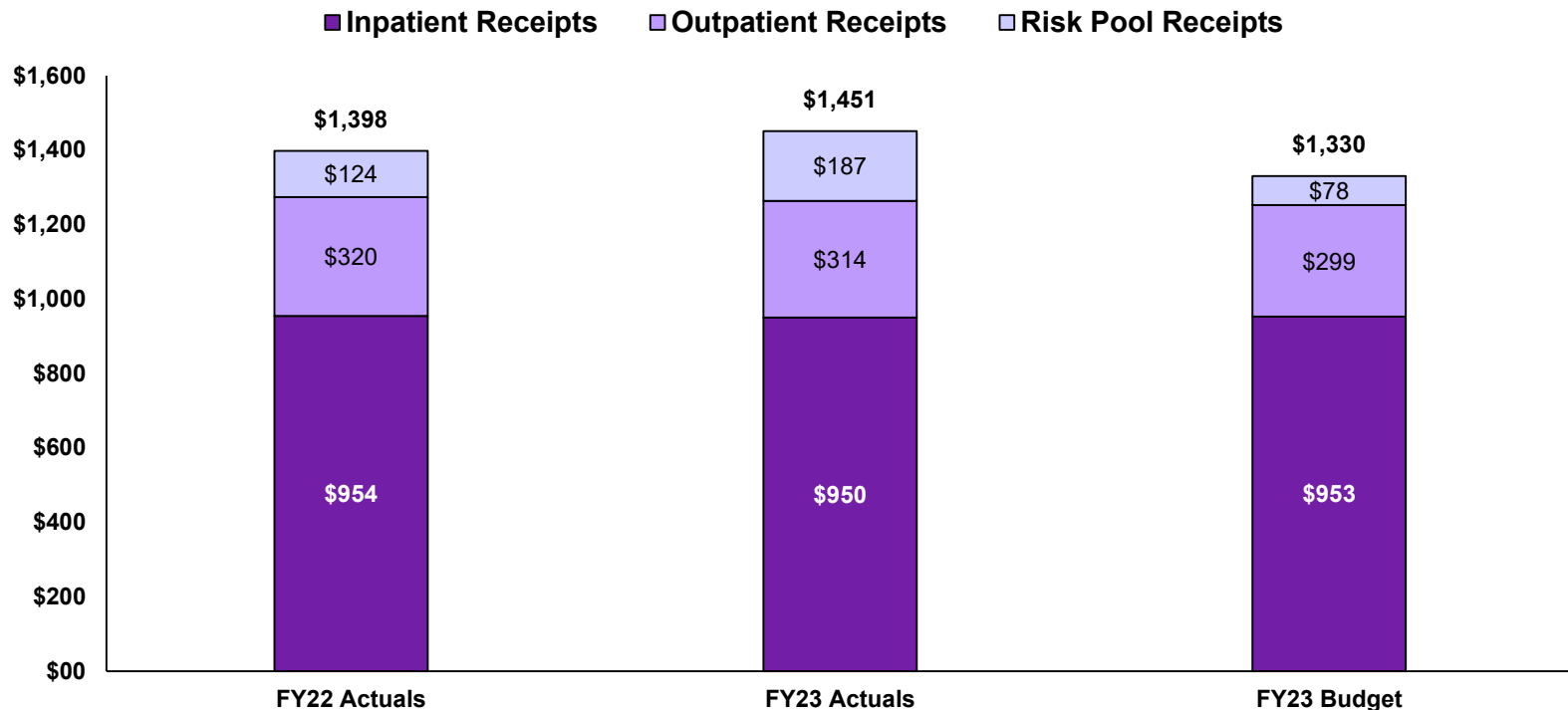
**excludes testing*

Cash disbursements are over budget by 3% primarily from unbudgeted COVID and Temp spending and Agency costs exceeding target.

- COVID Emergency Spend (-\$36M) – 47% of the spend is on staffing and temp costs particularly in the areas of Nursing and Credentialed Providers addressing COVID coverage needs. Remaining spend is on non-staffing costs including medical supplies, labs and other COVID support needs.
- Non-COVID Spend attributable to volume increasing to pre-COVID levels with associated need for immediate patient care coverage as the system rebounds from the COVID emergency impact and redirects its attention to full time staff recruitment in alignment with established staffing models.
 - Agency Patient Care Temp Staffing (-\$68.0M)
 - Other Discretionary Spend (\$34.0M) - increased days in AP and other billing timeline extensions

Summary Disbursements Performance (FY23 thru Sept)		YTD Variance against Budget (\$M)
COVID Emergency Coverage (Staffing and Non-Staffing OTPS).		(\$35.9)
Agency Patient Care Temp Staffing Coverage		(\$68.0)
Other Discretionary Spend		\$34.0
Grand Total		(\$69.8) [-3%]

- FY23 direct patient care revenue (I/P & O/P) is -\$10.8M lower than FY22 actuals.
- Patient revenue decrease year-over-year can be attributed to South Brooklyn bill hold post name change, as well as recoupment of UPL overpayment.
- Compared to same time last year, discharges are up 3.8%, visits are up 2.3% (excluding testing) and Case Mix Index (CMI) is flat 0.0%.



FY23 Highlights



Nov 24 Financial Plan - PEG

- OMB released the Nov 24 Financial Plan on Tuesday, 11/15.
- As part of the Plan, H+H along with all other City agencies, was given a City Tax Levy (CTL) budget savings target also known as a Program to Eliminate the Gap (PEG) of 3% in FY23 growing to 4.75% in FY24+.
- H+H met its PEG target by finding a number of savings and efficiencies. The implementation of the PEG will not have any adverse programmatic impact.

(\$ in millions)	FY23	FY24	FY25	FY26	FY27
Total PEG Savings	\$ (14.1)	\$ (18.6)	\$ (20.6)	\$ (20.6)	\$ (20.6)

Revenue Cycle

Revenue Cycle Stars

FYTD 23 (through September)

	FY 19	FY20	FY21	FY22
Overall Stars	★★★★★	★★★★★	★★★★★	★★★★★
Cash Posted vs. Budget	-4%	12%	14%	14%
Outpatient FC Rate		35%	76%	91%
Candidate for Billing Days	8.2	7.5	4.8	4
Timely Filing Denial Rate			2.50%	0.25%
AR Days	116	108	58	50

- Progressed from <1 to 4 stars
- Update targets and metrics as outcomes improve
- FY 23 continued focus on outpatient financial counseling, denials, and AR days

KPI Description	Interim Goal	Acute Total ★★★★★
Cash Posted		\$1158.5 M
Budgeted Cash		\$1091.7 M
Cash Compared to Budget	100%	106%
CASH		★★★★★
PATIENT ACCESS*		★★★★★
Inpatient Financial Clearance Secure %	98%	99%
Outpatient High Dollar Financial Clearance Secure %	95%	94%
% of Uninsured Patients with a Financial Counseling Interaction (OP/ED/IP)	95%	89%
% Patients with FA Interaction Enrolled in Health Insurance or FA	95%	97%
Inpatient Payer Mix Selfpay %		3%
PATIENT ACCOUNTING		★★★★★
		Days \$
Candidate for Billing (CFB)	3.8	3.0 \$141.4 M
% AR >90 Days	21%	37% \$835.4 M
Timely Filing Denial Rate	0.14%	0.30%
OUTCOME METRICS		☆☆☆☆☆
AR Days ¹	45	50.2
Administrative Write-Offs ²		\$64.2 M
Administrative Write-Off Rate	3%	4.6%

¹AR Days goal of 45 reflects HB Epic only.

AR Days goal and ² Administrative Write-Off Rate goals have been set and adjusted for the current Net/Gross environment at NYCH+H and will continue to be evaluated over time.

Test and Treat

Test and Treat Financial Update

- ❑ T2 has committed approximately \$111.8 million in expenses for Q1 in FY23
- ❑ OMB has provided H+H with sufficient revenue through the T2 MOU to cover expenses to date

Program Area	Total FY23 Projected Expenses
Testing	\$ 245.4M
Tracing	\$ -
Take Care	\$ 19.3M
Vaccine	\$ -
Data Analytics, Program Management, and Public Awareness	\$ 23.5M
Total Expenses	\$ 288.2M