FINANCE COMMITTEE AGENDA

Date: July 1, 2024
Time: 11:00 A.M.
Location: 50 Water Street, 17th Floor,
Boardroom – In Person

I. **Call to Order** *Freda Wang*
Adoption of the May 6, 2024 Minutes

II. **Financial Update** *John Ulberg*

III. **Old Business** Freda Wang

IV. **New Business**

V. **Adjournment**

Finance Committee MEETING – May 6, 2024

As Reported By: Freda Wang

Committee Members Present: Mitchell Katz, MD, Freda Wang, José Pagán, Sally Hernandez-Piñero, Barbara Lowe

CALL TO ORDER

Ms. Wang called the meeting of the New York City Health + Hospitals Board of Directors Finance Committee Meeting to order at 11:02 a.m.

Ms. Wang called for a motion to approve the March 11, 2024 minutes of the Finance Committee meeting.

Upon motion made and duly seconded the minutes of the Finance Committee meeting held on March 11, 2024 were adopted.

FINANCIAL UPDATE

Mr. Ulberg opened the presentation with the FY-24 Quarter 3 Highlights. He conveyed that March closed with $708M (26 days cash-on-hand). The budget overperformed by 1% and closed YTD February with a positive Net Budget Variance of $155.7M.

Mr. Ulberg continued that direct patient care receipts came in $325M higher than the same period in FY-23 due to continued increases in IP and OP services in FY-24, UPL Conversion, and overall improved cash performance. IP Patient care volume in FY-24 has surpassed pre-COVID levels (1.5%) and OP visits are 9.3% ahead of FY-20 pre-COVID levels. Revenue base remains strong and resilient primarily driven by returning volume and higher average collectability rate over the base. Overall, our strategic financial initiatives are ongoing. YTD Q3 performance generated $824.7M against an annual target of $1.08B. Financial updates through this period are still in progress as some initiatives have been impacted by the interruption of Change Healthcare. Several areas of strong Q3 performance were noted.

Mr. Ulberg presented the cash projections for FY-24. The System is estimated to close April with approximately $600 million (21 days cash-on-hand) and expects to close May with approximately $600 million (21 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.

Mr. Ulberg continued presenting the external risks. Several areas of focus include the Staffing Glidepath, temp services, and sessional costs, which continue to present a financial challenge. Full-time RN hiring is well

ahead of target by 575 RNs, beating the glidepath, and temps are meeting the glidepath reduction targets as orientation is complete which ranges from 3 to 6 months, and potentially beating the 18-months glidepath target. A sessional and locum expense reducing glide path has been implemented and is assumed to start in FY-24 Q3, reaching target by the end of FY-25.

H+H is diligently working to address inflationary pressures which continue to present a strain on and risk to our cost reduction plans. Facilities submitted gap closing plans to reduce spend and generate revenue. Timing to achieve the spend reductions is at risk due to increased pharmacy and Medsurg Supply Costs driven by inflationary challenges, increased patients, and higher acuity patients that require more expensive drugs and services. Medsurg spending is projected to increase 46% since FY-19, driven by inflation and increased volume.

City and State budgets currently presents a low risk to H+H. OMB released its Executive Plan on April 24th, with no PEGs in this plan. Moreover, H+H continues to review the impacts of the SFY-24-25 Enacted State budget which passed on April 20th. A summary of the major SFY-24-25 Enacted State budget provisions detailed were noted.

Medicaid Recertification is currently meeting our budgeted recertification targets and continues to optimize our overall strategies to ensure that we stay on track.

Lastly, the Change Healthcare (CHC) Cyberattack presents a lower financial challenge to H+H as we continue to make progress. The incident has national impacts, primarily on health care provider organizations, retail pharmacies, and payors, which use CHC technologies/services. H+H has reconnected with CHC for pharmacy and has connected to Experian for claims processing and eligibility transactions. H+H continues to wait for responses from some health plans regarding waivers as outlined by Department of Financial Services Circular Letter.

Mr. Ulberg provided an overview of the State Budget. There were positive and negative highlights from the SFY-24-25 Enacted Budget. Several positive highlights included the Hospital and Nursing Homes Medicaid Rate increases, Expands of Access to Primary Care, Essential Plan and Medicaid Coverage Provisions, Safety Net Transformation Program, Behavioral Health Investments, Workforce Proposals, and Health Care Stability Fund/HMO Tax. Some of the negative highlights included the Partial Reduction in Managed Care Quality Pools, 10% Capital Reimbursement Cuts on top of existing 10% Cut for Hospitals and 5% Nursing Homes, and 1% across the board cuts to health plans.

Dr. Katz inquired on the 1% across the board cuts to health plans. Is that the State looking at their balance sheets?

Mr. Ulberg agreed and added that looking at all those cuts, the State was just trying to get to a target.

Dr. Katz continued, the State is adding and subtracting noting that they need to also add initiatives. There is some data that suggest that plans really have been taking unfair profit and just wondering if the 1% across the board is based on them reviewing the balance sheet of plans and feeling like this is doable, or is it just we have got to close the gap somewhere and people hate plans, go ahead and do it there.

Mr. Ulberg responded that this is probably a combination of trying to hit the budget target. In his old job, you would always pay attention to that point, how much profit is being made and are you setting the right rate? At the end of the day, the State still has to set a rate that is reasonable and fits within the bounds that would be accepted by CMS. At one point they were trying to reach closer to the 25% of the range and is a combination of things. For H+H it becomes a direct cut due to our relationship with Healthfirst and MetroPlus. It is not a cut to us from most other plans where we do not engage in capitation arrangements, but that is a direct cut.

Dr. Katz asked if it affects every single line of plan business or just certain lines of the plan.

Mr. Ulberg responded that they set the premium and they cut it once. The total premium would just be reduced from where they would set it by 1%. It will still be a year-to-year increase as they need to factor in inflation, utilization increases, those are all part of the rate setting process but they will take a reduction of 1% that is part of the process. We do not like it but it is a real improvement from the Executive Budget to where they landed in the final budget. The Executive Budget had many deep cuts that were in essence, quote bought back, but next year will be interesting with the HMO tax, we will watch that carefully.

Ms. Hernandez-Piñero inquired on the focus on the Essential Plan, doing all pools more for Essential Plan in reducing for Medicaid. There seems to be a real focus on the Essential Plan, increasing the income level eligibility. There was an article talking about QHP and people falling out of QHP into essential plan.

Mr. Ulberg responded that we have added a slide on this and will be talking about this. We asked the question of why would you cut, and it goes back to Dr. Katz point about the budget, and trying to hit certain targets. The Essential Plan is 100% Federal funded, so they will go there first to try to maximize those Federal dollars and that is more than likely why they increased the quality pool there, but cut it on the Medicaid side. It is always important to maintain parity where you can, as the incentive structure will have an effect, and everybody knows the essential plan is a pretty rich plan at this point. The rates are very desirable level compared

to Medicaid, but you need to always be mindful of keeping that balance as it will drive incentives that perhaps you do not want to create.

Ms. Lowe inquired on prison health and the potential movement occurring to move the work efforts further north.

Dr. Katz clarified that she meant upstate, Ms. Lowe agreed. This is due to workforce being less expensive upstate.

Ms. Farag presented the financial performance highlights for FY-24 thru February Net Budget Variance. She noted that February ended with a net budget variance of $155.7M (1%). Receipts exceeded budget by $464M primarily driven by Patient Care and Risk Revenue. Risk is higher due to improved PMPM and other PY reconciliations. Disbursement exceeded budget by $308M, which includes expenses associated with Temp coverage, Affiliation, Discretionary OTPS, and Overtime costs.

Ms. Philogene provided the FY-24 thru February performance drivers updates. Cash receipts are 9% ahead of budget. Much of the overage can be attributed to Risk revenue exceeding target due to higher than anticipated PMPM and PY reconciliations. FY-24 thru February, cash disbursements are over budget by 5% primarily resulting from Temp spending and Agency costs exceeding target.

Ms. Wang asked if there is breakdown of what is due to inflation and due to higher volume.

Ms. Philogene responded that for volume we are seeing about 40% and then the balance is inflation. We do have some analysis for each separately on pharmaceuticals and medical supplies, and hopefully some of the savings that we realize in temps perhaps can cover some of the spending on that side.

Ms. Wang asked regarding the temps, the $130M expense, even though on the glidepath we are ahead of schedule but the dollars have not been realized.

Ms. Farag responded that there is a lag between off boarding the temps and then starting to see the annualized fiscal dollars, so it is not immediate. Most of the reductions have been after the settlement of the NYSNA contract in August so it takes a lag of hiring first our full-time staff, or putting them through orientation properly for safe transition, to transition the temps off so there is a lag by the point of the temps transition off. Most of the progress we have seen has actually been in the last couple of months, or the last quarter. That is on actual off boarding of the actual staff, the temp staff, and then you start to see the financial savings come after that, now you are reducing post them leaving.

Ms. Wang added that when we are kind of projecting out for the next budget, we want to think about that time because this is a pretty big swing, $175 million, so even though our timing is on track or ahead of schedule, the dollars are not.

Ms. Farag agreed and added that we do not see the larger dollars immediately but you will see larger financial gains in FY-25.

Mr. Ulberg added that we are very confident that the savings will materialize as Natalia and her team actualize the contract on a nurse by contract nurse basis, knows when they are going to depart, knows who has been hired and where they are in their training path; knows who needs to exit and the processes underway. Ms. Farag added, that she knows on the individual level by facility issues, meeting with facility weekly, and is really a great effort.

Ms. Lowe commented that there are some common factors that we can expect this time of the year, new grads. They run to us for orientation, and then they have a plan to move out of New York or do whatever, go somewhere else, and it is always that way. But we have done phenomenally much better than we have done in years.

Ms. Farag added, absolutely, the progress is evident in our hiring so it has been really great.

Ms. Lowe added that when personally going to the facility, she loves seeing their faces as everyone is happy.

Ms. Wang commented, that is great.

Mr. Ulberg added that it is a great point, as it gives us the chance to change the culture. With many new nurses, Natalia has done a great job with that training program, and on the way out the door we are recruiting the contract nurses as they go. We will tell them, we have enjoyed having you and we have a job for you so they can still choose. Things are moving well there.

Ms. Wang commented that we are 1% ahead of budget which is great although this does not reflect some of the Change Healthcare impact, but we will hear that it is coming along as from the cash forecast, it looks like we are going to recover from that. The one thing to note is that some of the variances, we are fortunate we have high variances on the revenue side as it is offsetting the high variances on the expense side, so in terms of risk pool performance, the 79% better than expected PMPM performance that we cannot anticipate necessarily, is that correct?

Ms. Farag responded that the ones that we have the reconciliation is for the prior year for one-time, and the PMPM improvement will be doing more. We will be able to see that continuity, but there is definitely a lot of that. Ms. Wang added, the 26%. Ms. Farag agreed.

Ms. Wang continued, when we review the risk pool we may see that might start to change, is that correct? Mr. Ulberg agreed. Ms. Wang added that it is factored into our budget moving forward.

The revenue performance for FY-24 thru February was presented by Ms. Philogene. FY-24 direct patient care revenue (IP and OP) is $325.2M higher than FY-23 actuals. Patient revenue increases year-over-year can be attributed to approved State Medicaid increases, Federal approved Billing UPL, overall increased volume and cash performance on revenue improvement initiatives.

Ms. Karlin provided an update on Medicaid Recertification results that remain in line with NYC Health + Hospitals Financial Plan 2/3rds of the way through. NYC H+H is currently averaging 79% for June 2023 through February 2024 cohorts recertified from the biggest health plan partners. Recertification percentages for MetroPlusHealth and Healthfirst members dipped over winter holidays but are showing signs of recovery in February and March 2024, which is not complete. Further, atypically high recertification percentage for Healthfirst for December 2023 cohort is primarily driven by automatic extension of coverage for large cohort of aged, blind and disabled members with coverage through LDSS-HRA who were due for recert in that month.

An overview of NYC Health + Hospitals continuing to make progress in recovering from Change HealthCare Cyberattack was presented by Ms. Karlin. Change HealthCare, NYC Heath + Hospitals vendor for claims clearinghouse, experienced a cyberattack on 02/21/24. In terms of Cash Flow management, H+H is closely working with our City, State, and Federal partners to expedite approved funding to H+H and prioritize review and approval of pending initiatives and current-year reimbursements. H+H has notified National Government Services (NGS) about the interruption in order to avoid PIP timeliness reviews; Medicare payments have been steady. Insurance payments are starting to come in based on recent claims submissions, and H+H continues to have ongoing conversations with managed care partners to afford leniency related to timely filing and appeals deadlines. Revenue Cycle is accelerating planned implementation of paperless billing - live since 02/28, and expedited planned 7/1/24 implementation of Experian clearinghouse for eligibility, authorization, claims and remits. H+H is live with eligibility and claims with the exception of real time eligibility and dental claims. H+H is not live with remittances and expect to go live on Experian by June 1st. The live dates for eligibility, claims and remits were noted. Revenue Cycle continues to optimize Experian implementation in the weeks and months ahead, and currently working with facilities to address backlogs in eligibility and claims/denials follow-up.

Ms. Wang asked how do we think this will show up in our financials.

Mr. Ulberg responded that the complete recovery plan we had discussed have a three-phase recovery plan each one being 6 weeks. We were fortunate that we had cash balances available that carried us through the first 6 weeks. The second six weeks, we were working closely with our City partners to move funds back and forth, and the final phase is tracking how are we doing

with denials which we are asking our insurance partners to be flexible with us in terms of the processing of the denials, and we are making progress there. We do a lot of business Medicaid Fee for Service business with the State and having them be good partners with us in terms of how they treat the denials, and allow appeal denials, will be important. We have asked them to just follow the guidelines set out by the Department of Financial services, so we do not anticipate it being an issue. The other important part of phase 3 is dealing with our Federal and State partners, we have two significant transactions that were built into the plan for the year. The first is inpatient UPL, which is a transaction initially approved by CMS last year, they renewed that approval almost 3 months ago. It is our understanding that the status of that package has moved from the Health Department over to the budget division and that is the last step. But again, time is of the essence there, as to effectuate the transaction it takes at least 6 to 7 weeks since there are other things that we have to do in terms of moving the money between us and the State, and then the plans back to us. It is just part of our plan. The last transaction is outpatient UPL which is new to CMS and they have not done that before. Dr. Katz added that we mainly focus on timing, making sure we can pay our bills, but if we put that aside for a second at the end of the day, would we lose money due to this?

Mr. Ulberg responded that we are not sure but there is a possibility that we could lose money on the denial remittance part of the glitch here, but Bob has been looking at our cash and it is about 94-96% of where we should be with cash, some of that is the denials and it will come back. We make our living we say on the last 1%, and 1% makes the difference, that’s the margin that we work with here.

Ms. Karlin agreed and added that from a pure operational standpoint, if the payors do not all cooperate with the extensions, that is the possibility of where we lose money. If they cooperate, it is going to take us some time to dig out from under these, but from the payers that we are getting the remit files we are seeing as expected higher than typical denial rate for eligibility, because our eligibility was not live and we send it to the payer that we had on file not necessarily the right payer. And so, we were scoring and trying to address all of those in a priority manner, and then we have the denials sort of laid out in a priority order. For instance, if a payor comes back and said you were too late to bill us because we did pass their timely filing and we could not post the remit file from 4 months ago, that is the danger. But we are labeling and categorizing everything to fight it down to the last dollar.

Ms. Wang asked if there have been any regulations from the Federal government to extend this.

Ms. Karlin responded that there has been guidance. CMS gave their guidance as to what they were planning to do, but it is not regulation.

Ms. Wang added that payors have the option to not do it.

Mr. Ulberg added that DFS, Department of Financial Services regulates the non-Medicaid insurers, issued very direct guidance and what we do is keep track of who is in fact recognizing that we have issues and who is not. The best that we can do is to inform them really on a claim by claim basis of what is kind of fallen within being classified as an impact related to Change. We are fairly successful with even the State, we have a file for claims that fit within the denial period that we want you to recognize. And again, we even had to attest to DFS that we in fact had these various issues that we were requesting that the insurers address. We do not believe it is over, and it is not as big of an issue as we move quickly and other providers have moved quickly to try to switch to another clearing house and put in other systems.

Dr. Katz commented that Sally is the only lawyer at the table, that if we were to lose money because of insurers unwillingness to go beyond the date, would we not have a legal case claim against Change Healthcare? This is a company that had a $300 billion dollar profit last year, they are not going bankrupt. No matter how many claims, they are not going bankrupt.

Ms. Karlin responded that OLA is looking at that as well, and we are as well ticking and tying, and making sure we put everything into an appropriate bucket, all of our claims, all of our denials, and working through it as well as any expenses that we have incurred because of this. OLA is looking at our options.

Ms. Hernandez-Piñero answered that she thinks we will have to get in line and asked if we had an interim vendor before Experian.

Ms. Karlin responded that we did not. Change HealthCare was our vendor, and the board approved a transition from Change Healthcare to Experian. We were just able to leverage that Experian contract to implement it earlier.

Dr. Katz added that we just started sooner and depending what you think, it was either brilliant judgement but we got very lucky, as we were able to start it earlier. We are lucky we were prepared.

Mr. Ulberg added that it raises the issue of this redundancy. Do we need to have redundancy? Once we put this behind us, we will come back and answer that question of do we need to have redundancy to be prepared.

Ms. Hernandez-Piñero added that MetroPlus tried to have the redundancy built in, and then companies kept getting swallowed up, so everyone that you were using for redundancy was taken over.

Ms. Karlin added that we have already started engaging in that conversation with IT and we will see what their recommendation is.

Ms. Wang commented that from a timing standpoint, it sounds like the team has back up plans and back up plans, and the bigger question is, are we actually out a loss.

Mr. Ulberg added that we will report back on it.

Ms. Wang continued that the team is doing everything possible to prevent that but obviously that is the question.

Mr. Ulberg added that we are keeping track of it, we are tagging each claim as well.

Ms. Meagher provided an update on the Risk Surplus for Year-End 2023. Significant surplus payments achieved in 2023, but expecting much less surplus in 2024 due to NYS Medicaid and Healthfirst Medicare premium rate cuts against consistent medical spend. Membership remaining mostly flat due to strong Essential Plan performance and high Medicaid recertification rates.

Ms. Lowe asked if there is any one population that we can look at a little further, maybe adolescents and pediatrics.

Ms. Meagher responded that we can. We can definitely try to see what is changing with our pediatrics population, what proportion. They should mostly be in the blue bar, kids do not qualify for Essential Plan, we can try to quantify what proportion of that bar are kids and CHP.

Mr. Ulberg added that anyone who has been involved in measuring risk surpluses has never seen the performance that we saw this year. It was just quite remarkable for many reasons. We take that information when they set their budget, we try to triangulate between what we are seeing in the data, what Healthfirst sees, and what MetroPlus is also seeing. When we are setting our rates, we have the advantage of having the information from two other plans. So, when we do the FY-25 budget we will take that all into account that there will be some sort of drop and as Megan pointed out, we can already start to see it. Healthfirst is on a January calendar year basis, they predicted a drop but they are performing better than they had predicted due to the Medicaid rates that the State set in April was a little bit better than they had forecasted. Everybody is expecting a drop but how far the drop, we will have to see. But Healthfirst, first quarter, they are doing better than budget.

An overview of the recent changes in NYC Insurance market was presented by Ms. Meagher. Some recent changes highlights include starting in July 2023, Medicaid recerts contributing to growth in Essential Plan membership which is now tied to a much richer reimbursement rate. From a claims and surplus perspective there is more revenue. Starting in January 2024, Medicaid Managed Care coverage was newly eligible for undocumented seniors over the age of 65. Starting in April 2024, the Essential Plan further expanded to

Essential Plan 200-250 providing new, better coverage for individuals struggling to afford QHP coverage from HIE.

Dr. Katz added that the President made it possible for people who are dreamers to qualify previously DACA would not qualify for anything. How big of a population could that be, of people who are using our service presumable under NYC Care currently.

Ms. Meagher added that we believe this was part of the 1332 waiver.

Mr. Ulberg added that we will double check and get back to you on this.

Dr. Katz mentioned that it is good news, and it is something to watch and have some sense of what it would be. It shares in some ways the process of the seniors, they are in our System and we need to get them into a different program, presumably the same would be true for the DACA youth. Just need to figure out how to transition them.

Ms. Hernandez-Piñero added that they are eligible to enroll in a QHP through the marketplace.

Ms. Dehart commented that this is also a subject to CMS approval, same for the 1332 waiver that Megan referenced.

Mr. Ulberg added that a newly important regulation that the Biden administration released last week or the week before, aimed at health equity access to services, rate transparency and is very comprehensive. We are now going through the different elements of the rule. It was great to see them take such an active rule.

Ms. Wang added that it would be great to get a briefing on it.

Dr. Ted Long commenced the presentation with an overview of the HERRC program and a financial update. H+H currently oversees 14 H+H HERRC sites serving approximately 24,000 daily guests, a reduction of one HERRC site since Q2 close. At the 24/7 Arrival Center, over 131,000 asylum seekers have been served. H+H committed $1.2B of HERRC expenses on behalf of the City through Q3 of FY-24. In the City's Executive plan, H+H budget for the HERRC program is $1.6B in FY-24 and $1.7B in FY-25. OMB has provided H+H with revenue to cover committed expenses to date through the HERRC MOU with the Mayor's Office.

Ms. Wang polled the Committee for questions. There being no further questions, Ms. Wang thanked and commended the team for the great work.

ADJOURNMENT

There being no further business before this committee, the meeting adjourned at 11:58 A.M.

NYC Health + Hospitals
Finance Committee Meeting
July 1, 2024

FY24 YTD Highlights

- The system closed May with **$616 Million (22 days cash-on-hand).**
- Closed April with a **negative Net Budget Variance of -$62.2M (-0.4%).**
- Direct Patient Care Receipts (I/P and O/P) came in **$109.8M higher than the same period in FY23 due to** continued increases in IP and OP services in FY24, UPL Conversion, and Medicaid rate increases – despite delayed cash performance due to Change Health Care (CHC) billing issues.
  - Patient Care Revenue is recovering and expected to be back to budget by Fiscal Year-End.
- FY24 Patient care volume has surpassed FY20 pre-COVID levels with Inpatient discharges up by 1.7%, and Outpatient visits up by 10.6%. Revenue base remains strong and resilient primarily driven by returning volume and higher average collectability rate over the base.
- Strategic Financial Initiatives have generated $834.7M against an annual target of $1.08B through March. Financial updates through this period are still in progress as some initiatives have been impacted by the interruption of Change Healthcare. Initiatives with strong Q3 performance remain as follows:
  - Managed Care Initiatives High Cost Outliers ($166.7M);
  - Completed Managed Care Contract Negotiations ($78.7M);
  - Financial Counseling Enhancements ($66M)
- H+H also received $26.8M in Behavioral Health Centers of Excellence funds against an award amount of $41M. The System is investing in all areas of its Quality Improvement Plan that focuses on high-risk populations and high utilizers.

FY24 Cash Projections

- The system is estimated to close June with approximately $600 Million (21 days cash-on-hand).
- The system expects to close July with approximately $450 Million (16 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.

Managing Risks

Risk	Status
Staffing Glidepath (Temp and Sessional Costs) ○ Full time RN hiring is well ahead of target by 360 RNS, beating the glidepath, and temps are meeting the glidepath reduction targets as orientation is completed (orientation can range from 3 to 6 months). Temp reduction may potentially beat the 18 months glidepath target. (See Appendix #1) ○ A sessional and locum expense reducing glide path has been implemented and is assumed to start in FY24 Q3, reaching target by the end of FY25.	Yellow
City/State Budget ○ The City's Adopted Budget process is underway ahead of the start of the new fiscal year on July 1st. We do not expect major impacts in this plan. ○ H+H initial's assessment of the SFY24-25 Enacted Budget is net neutral; H+H continues to track the implementation of the budget provisions.	Green
Medicaid Recertification ○ We are currently meeting our budgeted recertification targets and continue to optimize our overall strategies to ensure that we stay on track.	Green
Change Healthcare (CHC) Cyberattack ○ The incident has national impacts, primarily on health care provider orgs, retail pharmacies, and payors, which use CHC technologies/services. H+H has reconnected with CHC for pharmacy and has expedited a planned connection to Experian for all clearinghouse functions. We continue to work with Health Plans on ongoing operational issues caused by the disruption.	Green

Financial Performance

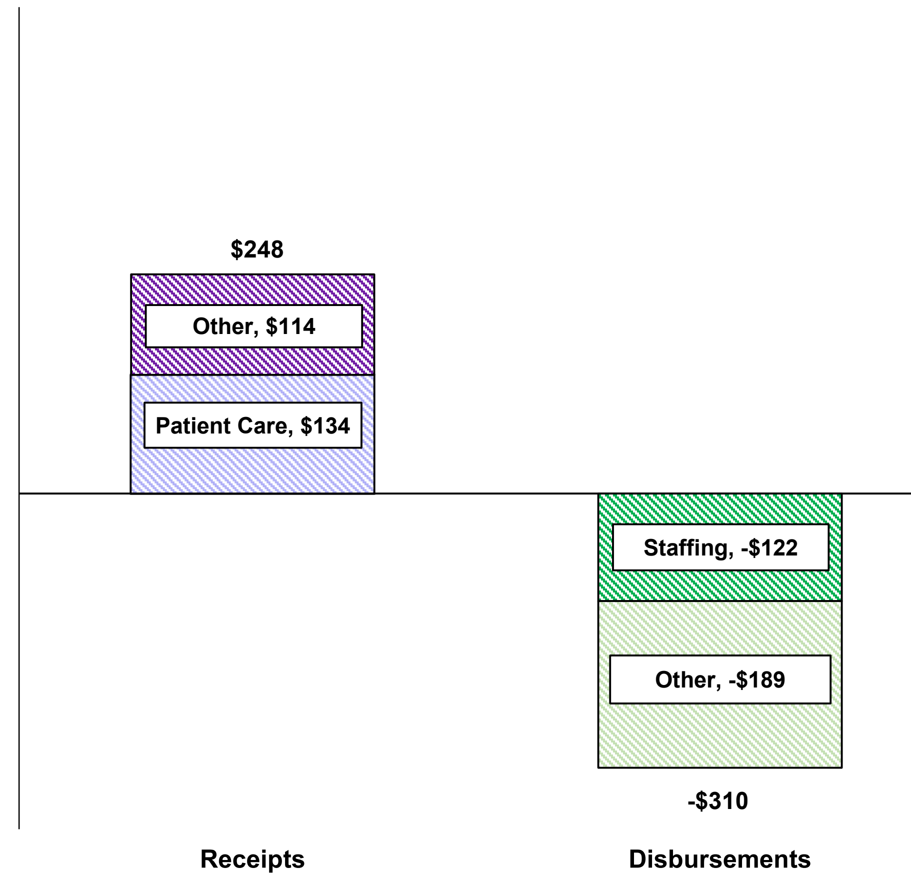
FY 2024 YTD

FY24 thru Apr
Net Budget Variance

Highlights

Ended Mar with a net budget variance of -$62.2M -0.4% where

- Receipts exceed budget by $248M Primarily driven by Risk Revenue. Risk is higher due to improved PMPM and other PY reconciliations.
  - Patient billing revenue is behind target by 3% due to the impact of CHC.
- Disbursements exceed budget by $310M, which includes expenses associated with Temp coverage, Affiliation, PS/Overtime costs, and other increased patient care costs.



Notes:

1. Test and Treat not included in the Net Budget Variance.

Cash receipts are 3% ahead of budget. Much of the overage can be attributed to Risk revenue exceeding target due to higher than anticipated PMPM and PY reconciliations

- IP/OP rates, volume, and cash performance **(-$121.6M)** - IP discharges are 2% ahead of budget and OP visits are 6% of budget. Billing Cash is behind the YTD target due to the impact of CHC.
- Risk Pool Performance and Timing **(+$280.1M)** - ahead of budgeted target by 79% primarily due to CY23 Risk PMPM performance coming in better than planned. 24% of the variance due to unbudgeted reconciliations being collected this year.
- Other revenue exceeding target **(+$89.4M) –** Miscellaneous interest payments, and other administrative collections. UPL came in higher than annual budget target.

Summary Receipts Performance (FY24 thru Apr)	YTD Variance against Budget ($M)
IP/OP Volume, Rates, and Cash Performance	($121.6)
Risk Pool	$280.1
Other	$89.4
Grand Total	**$247.98[+3%]**

NYC HEALTH+ HOSPITALS

Drivers of Expense Budget Variance

Cash disbursements are over budget by 4% primarily from Temp spending and Agency costs exceeding target and other increased patient care costs

- The System has redirected its attention to full time recruitment & retention of H+H and Affiliate patient care staff in alignment with established staffing models to support our clinal services and overall volume increases.
- Personnel Services including Overtime **(-$83.1M)** – this will improve with upcoming roll-out of staffing models and roll-out updates of newly implemented models.
- Affiliations **(-$38.6M)** – Sessional and locum usage
- Temps **(-$140.7M) –** as the hiring has ramped up, excess temp expenses have started to decrease as outlined in the System's glide path. In the past two months the average monthly payment has decreased by 43% compared to the first half of the fiscal year and will continue to decrease as newly-hired nurses complete orientation, and roll-off.
- Other Discretionary spend (**-$47.9M)** – Medical supplies and other patient care costs associated with increased inflation rates and delays in roll-out of some gap-closing initiatives.

Summary Disbursements Performance (FY24 thru Apr)	YTD Variance against Bud ($M)
PS/OT	($83.1)
Affiliations	($38.6)
Agency Patient Care Temp Staffing Coverage	($140.7)
Other Discretionary Spend	($47.9)
Grand Total	**(-$310.190) [-4%]**

FY24 thru Apr
Revenue Performance

- FY24 direct patient care revenue (I/P & O/P) is $109.8M higher than FY23 actuals. Year over year variances are understated due to Change Healthcare Billing issues.
- Patient revenue increases year over year can be attributed to approved State Medicaid rate increases, and Federal approved Billing UPL
- Compared to same time last year, discharges are up 2.4%, visits are up 4.8% (excluding testing), and Case Mix Index (CMI) is slightly higher by 0.9%.

	FY23 Actuals	FY24 Actuals	FY24 Budget
Inpatient Receipts	$3,221	$3,298	$3,391
Outpatient Receipts	$1,100	$1,133	$1,183
Risk Pool Receipts	$422	$631	$351
Total	$4,742	$5,062	$4,925

Revenue Cycle

Recertification Results Remain in Line with NYC H+H Financial Plan 3/4ths of the Way Through Unwind

- Averaging **78%** of June 2023 – April 2024 cohorts recertified for biggest health plan partners
  - Recertification %s for MetroPlusHealth and HealthFirst members dipped over winter holidays but are showing signs of recovery
  - Atypically high recertification % for Healthfirst for December 2023 cohort is primarily driven by automatic extension of coverage for large cohort of aged, blind and disabled members with coverage through LDSS-HRA who were due for recert in that month
- Continued focus on helping patients recertify whenever possible

Data from MetroPlus as of 6/6/24 and HealthFirst as of 5/23/24. Please note that members due for recertification can recertify through the end of the following month with no break in coverage if they remain enrolled with the same plan in the same line of business (and selected members with coverage through LDSS/HRA can recertify for an additional 4 months).

NYC H+H CONTINUING TO MAKE PROGRESS IN RECOVERING FROM CHANGE HEALTHCARE CYBERATTACK

CASH IMPACT

- Delayed claims lead to low cash collections in March and April
- Approximately $200M behind in cumulative cash collections through April
- ***Cash backlog fully recovered by mid-May***; ***work continues to fully recover cash owed***
- Pockets of claims require attention – Medicaid and other payers appeals are delayed

OPERATIONAL RECOVERY

PATIENT STATEMENTS:
- Accelerated planned implementation of paperless billing – Live 2/28 ✓
- Change Healthcare ceased statement operations; new vendor identified - planned go-live 7/24

CLEARINGHOUSE: Expedited planned 7/1/24 implementation of Experian; optimization ongoing

ELIGIBILITY
- Manual eligibility portal for end users – ***Live 3/18*** ✓
- Batch Eligibility – ***Live 4/1*** ✓
- Real Time Eligibility – ***Live 6/4*** ✓

CLAIMS
- Claim submission - ***Live 4/1*** ✓
- Dental Claims outstanding – Planned go-live 7/24

REMITS
- Reconnected with Change Healthcare for most payers; largest backlog is Medicaid
- Full transition to Experian expected by 7/15

Addressing backlogs in claims/denial follow-up due to delays in remit processing

FY24

VBP Update

CY2023 Healthfirst VBP Quality Program Results

Average Facility Improvement by Measure (CY23 vs CY22)

Measure	Avg Impr Medicaid*	Avg Impr Medicare*
Breast Cancer Screen	+3.5%	+4.7%
Cervical Cancer Screen	+4.1%	NA
Chlamydia Screen	-0.3%	NA
Colorectal Cancer Screen	-1.1%	+1.6%
HbA1c Control	+2.3%	+2.5%
Controlling BP	+2.0%	+0.9%
Followup ED Sub Abuse	+7.8%	NA
Followup ED Sub Abuse	+27.1%	NA
Ease Schd Appts	+1.1%	+0.4%
Well Visits 30M	-1.9%	NA
Well Child Visits	+2.7%	NA
CHOL Med Adherence	NA	+0.7%
HTN Med Adherence	NA	-0.8%
DIAB Med Adherence	NA	+0.6%
COA Med Review	NA	+0.9%

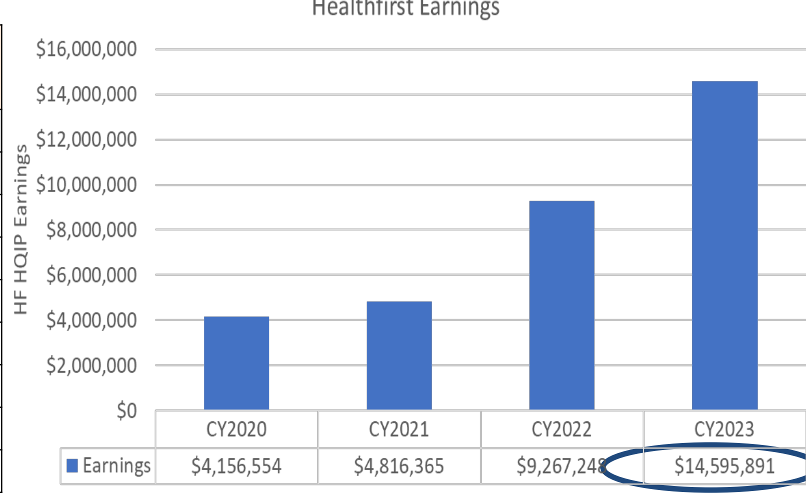
All but 2 measures improved over CY2022

Ranking in Healthfirst Network

H+H Facilities in Top 10 of Healthfirst's Network for Overall Quality Rating

Medicaid		Medicare	
Rank	**H+H Facility**	**Rank**	**H+H Facility**
2	Queens	1	Gouv
3	Elmhurst	2	Morrisania
4	Metropolitan	4	Belvis
5	Jacobi	6	Sydenham
10	Belvis	8	Cumberland
		9	Metropolitan
		10	Lincoln

Incentive Earnings



Highlights

- Highest earnings to date
- NYC H+H increased earnings by 57% ($14.595M)
- NYC H+H increased earnings by 251% since 2020

*Avg Improvement = percentage point change in average facility measure score from CY2022 to CY2023; NA = Measure not applicable for that line of business

CMS Final Rules- Issued April 2024

- This April, the Centers for Medicare and Medicaid Services (CMS) published consequential final rules for the 2025 Medicare Advantage Program and new access, finance and quality rules for the Medicaid and Child Health Plus programs (effective July 2024).
- There is an immense amount of detail in these Final Rules, but there are several important impacts that NYC H+H will be monitoring over the coming months and years:
  - New standards to enhance access and quality in Medicaid Managed Care and Child Health Plus value based contracts
  - Changes to Medicaid State Directed Payments
  - Requirement for Medicaid Managed Care plans who also offer Dual Special Needs Plans (DSNPs) to coordinate all benefits for members

FY25 Budget Development

FY25 Planning – Phase III

- Raising the bar in Managed Care and Revenue Cycle
- Amb/Care OP Growth
  - Provider template optimization and standardization
  - New patient access innovation
  - E-consult relaunch
  - Primary care staffing model
- Business plans and new cross-facility partnerships
  - Enterprise radiology
  - OR efficiency and expansion
  - Oncology services, therapies and treatment (cost/revenue potential)
- Physician Workforce Plan budgeting and recruitment investments/Continue locum reduction glidepath
- Managing increasing demand
  - Length of stay reduction investments
  - Overtime management
  - Infrastructure investments
  - Temp agency continued glidepath

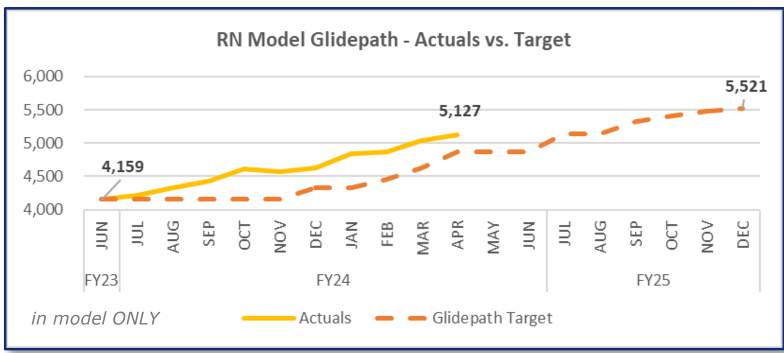
Appendix

Appendix#1

FY24/25 RN & Allied/Non-Clinical Glidepaths Update*

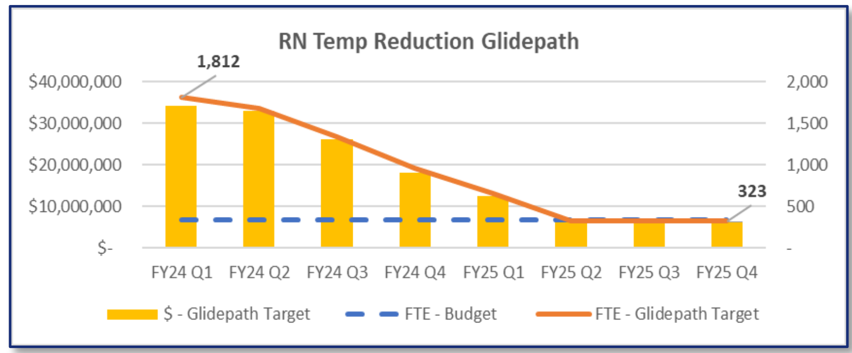
RN Glidepath Update

H+H FTEs



- Net increase of over **1,400 RNs s**ystem wide.
- **968 RNs** hired in the IP and ED nursing models since June 2023.
- H+H is **ahead of the YTD Glidepath target by over 360 RNs**.

TEMP FTEs



- Since June 2023, there has been a net reduction of **594 RN temps** systemwide (60% reduction within the IP and ED Models).
- H+H is **on track** to reducing a total of **1,489 RN temps** by the second half of FY25.

Allied & Non-Clinical Glidepath Update

- Since June 2023, there has been a decrease of **93 allied temp FTEs** and **124 non-clinical temp FTEs.**
- With successful execution of the allied and non-clinical temp glidepath, **315 excess temp FTEs** will be shed by the beginning of FY25.

**data as of April 2024*