AGENDA

FINANCE COMMITTEE

MEETING DATE: JUNE 10, 2014
TIME: 9:00 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER	BERNARD ROSEN
ADOPTION OF THE MAY 13, 2014 MINUTES	
SENIOR VICE PRESIDENT'S REPORT	MARLENE ZURACK
KEY INDICATORS & CASH RECEIPTS/DISBURSEMENTS REPORTS	FRED COVINO KRISTA OLSON

INFORMATION ITEM

1. STATEMENT OF REVENUE & EXPENSES AS OF MARCH 31, 204 & 2013	JAY WEINMAN
2. NYSDOH/EXCHANGES	DANIELLE HOLAHAN

OLD BUSINESS NEW BUSINESS ADJOURNMENT	BERNARD ROSEN

MINUTES

MEETING DATE: MAY 13, 2014

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on May 13, 2014 in the 5th floor Board Room with Bernard Rosen presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Bernard Rosen
Ramanathan Raju, MD
Josephine Bolus, RN
Emily A. Youssouf
Steve Banks, Commissioner, NYC Human Resources
Mark Page
Patsy Yang, (Representing Deputy Mayor Lilliam Barrios-Paoli in a voting capacity)

OTHER ATTENDEES

J. DeGeorge, Analyst, State Comptroller's Office
M. Dolan, Senior Assistant Director, DC 37
C. Fiorentini, Analyst, NYC Independent Budget Office (IBO)
T. Harkins, Vice President, Sales & Marketing
K. Lamb, Vice President, BSI Healthcare
J. Levy, Base Tactical
K. Raffaele, Analyst, OMB
J. Wessler

HHC STAFF

P. Albertson, Senior Assistant Vice President, Corporate Operations/Procurement
B. Ancona, Chief Financial Officer, (CFO), Gouverneur Healthcare Services
M. Brito, CFO, Coler/Goldwater Specialty Hospital & Nursing Facility
L. Brown, Senior Vice President, Corporate Planning, Community Health & Intergovernmental Rel
E. Casey, Director, Corporate HIV Services
D. Cates, Chief of Staff, Board Affairs

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M. Arias-Clark, Assistant Director, Corporate Budget
A. Cohen, CFO, Southern Manhattan Health Network
D. Collington, Director, Coney Island Hospital
F. Covino, Corporate Budget Director, Corporate Budget
K. Depass, Assistant Controller, Coney Island Hospital
R. Desai, Analyst, MetroPlus Health Plan, Inc.
L. Free, Assistant Vice President, Managed Care
K. Garramone, CFO, North Bronx Health Network
M. Genee, Deputy Corporate Comptroller, Corporate Comptroller's Office
G. Guilford, Assistant Vice President, Office of the Senior Vice President/Finance/Managed Care
L. Guttman, Assistant Vice President, Intergovernmental Relations
J. John, CFO, Central Brooklyn Health Network
M. Katz, Senior Assistant Vice President, Corporate Revenue Management
B. Keller, Deputy Counsel, Office Legal Affairs
Z. Kelley, Assistant Director, Office of Internal Audits
D. Larish, Director, Operations/Contracting
J. Linhart, Deputy Corporate Comptroller, Corporate Comptroller's Office
P. Lockhart, Secretary to the Corporation, Office of the Chairman
P. Lok, Director, Corporate Reimbursement/Debt Financing Services
N. Mar, Director, Debt Financing/Reimbursement Services
A. Marengo, Senior Vice President, Communications & Marketing
A. Martin, Executive Vice President, Office of the President
I. Michaels, Director, Corporate Communications/Marketing
A. Moran, CFO, Elmhurst Hospital
D. Moskos, Director, Office of Facilities Development
K. Park, Associate Executive Director, Queens Health Network
J. Quinones, Senior Assistant Vice President, Operations/Corporate Contracting Services
C. Samms, CFO, Generations Plus/Northern Manhattan Network
W. Saunders, Assistant Vice President, Corporate Intergovernmental Affairs
P. Slesarchik, Assistant Vice President, Corporate Labor Relations
B. Stacey, CFO, Queens Health Network
R. Walker, CFO, North Brooklyn Health Network
J. Weinman, Corporate Comptroller, Corporate Comptroller's Office
D. Wilson, Director, Office of Legal Affairs/Real Estate
R. Zhu, Senior Associate Director, Metropolitan Hospital Center
M. Zurack, Senior Vice President, Corporate Finance/Managed Care

CALL TO ORDER **BERNARD ROSEN**

The meeting of the Finance Committee was called to order at 9:10 a.m. The minutes of the April 8, 2014 Finance Committee meeting were adopted as submitted.

CHAIR'S REPORT **BERNARD ROSEN**

Mr. Rosen welcomed Mrs. Bolus' return, Mr. Banks, Commissioner, HRA newly appointed to the Committee and Ms. Yang, representing Deputy Mayor Lilliam Barrios- Paoli in a voting capacity.

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

Ms. Zurack informed the Committee that her report would include an update of the City's Executive Budget; HHC's cash flow and a review of the Delivery System Reform Incentive Payment (DRIP) funding. The City's Executive Budget was released last week with very limited changes for HHC. There was on minor adjustment of less than $30,000. There were no PEGs or new needs for HHC. HHC's cash flow problem which has been reported monthly at this Committee continues to be at risk due to the probability that there might be slippage in some of the UPL payments from the State. As of May 9, 2014, HHC's cash balance was $210 million or 13 days of cash on hand (COH), which is dangerously low. There are a number of outstanding retroactive UPL payments that are funded 50% City and 50% Federal. The process for securing those payments requires an agreement between NYS and Centers for Medicare & Medicaid Services (CMS) on some of the calculations. There have been some discussions between those two entities regarding the methodology. However the state has agreed to accelerate some of the DSH payments to HHC that would have been made in the first quarter of next fiscal year into the current quarter which would alleviate the current cash flow situation.

Ms. Youssouf asked if the advancement of those payments would be reduced from what HHC is due. Ms. Zurack stated that it would be an acceleration of those payments. However, there is an issue with one of the larger payments totaling $432 million, which was initially expected to be an easy review process but is now being questioned by CMS. HHC has developed two cash flows with those two proposed assumptions of which one assumes that the inpatient UPL payments will be received as plan and the cash will be sufficient through the end of the FY 14. The other scenario assumes that the payments will be delayed until the first quarter of next FY 15 which would mean that HHC cash would drop below four days of COH during the week of June 6, 2014 and on the last day of the year when HHC makes all of the payments to the City totaling $845 million, HHC would go negative.

Ms. Youssouf asked what was included in the $845 million payment to the City. Ms. Zurack stated that it includes malpractice payment and GO debt on HHC's behalf.

Ms. Youssouf asked if those payments were deferred. Ms. Zurack stated that those payments were deferred from last year to this year.

Mr. Rosen added that it is a double payment.

Ms. Youssouf asked if the City's budget included those payments from HHC. Ms. Zurack stated that the FY 13 payment was set aside on the City's FY 13 books as a payable from HHC and a receivable for the City. The City's 14 books have not yet closed. Therefore, it is in the budget for FY 13 and FY 14. Before moving to the last item in the reporting, Ms. Zurack announced the retirement of Roslyn Nunez, Senior Director, Revenue Management who retired last month after more than thirty five years of service. Ms. Nunez began her career with HHC at Coney Island Hospital and later moved to Corporate Revenue Management as a Senior Director for all of the revenue management data. HHC extends its congratulations to Ms. Nunez on her retirement.

Ms. Zurack moved to the final item, the DSRIP funding bringing to the attention of the Committee the DSRIP chart that was taken directly from the State's website and was included in the package. The chart is also included in the terms and conditions of the 1115 waiver.

Mr. Rosen asked what the purpose of the chart was. Ms. Zurack stated that the purpose was to show the way in which the State will fund the DSRIP program and the mechanism that is being used and what the funds will be used for on a statewide basis. HHC at this point does not know what it will be getting. However, what will be discussed is the process and how the determination of what HHC will be getting will be made. The chart was intended to display the sources of funds for the $8 billion 1115 waiver and the usage of funds. The Medicaid program is a matching program that is comprised of City, State and federal financial participation (FFP), the matching funds from the federal government. The chart has been developed in an unusual way in that it is not being displayed in total funds but rather uniquely by the sources which are the matching funds and the uses which are the spending of the federal funds. The purpose of reporting this information is to inform the Committee and the Board before HHC completes the process of applying for the funds and exactly where the source of the funds for the matching funds will come from which will affect HHC and how the uses for the distribution will be determined. The State has argued that NYS through the Medicaid Redesign Team (MRT) has dramatically changed the Medicaid program of NYS. As a result of that change the federal government has realized significant savings given that the new Medicaid program is less expensive than the old one. Therefore, the federal government through the 1115 waiver process should reinvest the savings back into the healthcare system to allow the system to adapt to the changes that were developed by the MRT. In August 2012, the NYS submitted its application and was recently approved. Essentially, the MRT waiver amendment is an agreement that allows the State over five years to reinvest $8 billion in federal savings generated by the MRT reforms to implement an action plan to save and transform the State's healthcare system; change the Medicaid cost curve and assure access to quality care. A large part of the discussions have centered on how the State will provide matching funds. The top portion of the chart reflected the sources of the matching funds for the $8 billion consisting of two sources, $2 billion and $6 billion. The $6 billion will come from the Intergovernmental Transfers (IGT). In essence, any other element of the local government a local taxing entity may pay the State money and it may be used for Medicaid but not considered a provider payment and will not be subject to prohibitions against providers paying the local share of Medicaid.

Ms. Youssouf asked where the State is expecting the funding to come from. Ms. Zurack stated that there is an exception which is the IGT. In other words, it is forbidden for Mount Sinai hospital to pay the local share of Medicaid that could result in the States paying nothing which occurred some years

ago. Another exception is that government hospitals are not held to that same standard. There is a prohibition that is called recycling. If a local government hospital paid the local share of Medicaid and receives a Medicaid payment that payment must remain with the hospital for the 1115 waiver. $6 billion of the total matching funds of $8 billion must come from the public hospitals throughout the State making the IGT.

Ms. Youssouf asked how much HHC is on the books for. Ms. Zurack stated that it is not yet determined in term of the distribution between public hospitals. The public hospitals at issue are SUNY and its three medical centers, HHC, Eerie, Westchester and Nassau counties.

Ms. Youssouf asked for clarification of the $6 billion. Ms. Zurack stated that it was over a five year period.

Mr. Rosen asked for clarification of Year 00 for the first year. Ms. Zurack explained that Year 00 started last month the first year is April 15, 2015. The next category is called the designated safe programs. In the last several waivers the federal government has allowed the states including NYS to identify a certain amount of healthcare that is not for the Medicaid population that would be counted as matching for Medicaid dollars such as the early intervention services for children who are above the level of Medicaid eligibility but the State pays for it. The remaining $2 billion funding is for designated programs operated by the State that were not Medicaid programs that were included in the last Waiver and had been the source of local match. Those are the sources of the local match.

Ms. Youssouf asked how the State will spend the $8 billion in matching funds. Ms. Zurack stated that the first year which is called the Interim Access Assurance Fund (IAAF) of $500 million will be used to provide cash flow relief for hospitals that are safety net hospitals with significant financial problems, consisting of $250 million for public and $250 million for non-public. The requirements for those funds were released last week and are slightly different for the public than for the non-profit.

Ms. Youssouf asked if the process is a mandate for the State. Ms. Zurack stated that the process which was defined by the State must be implemented according to that plan. HHC will be applying for the IAAF which is due by the end of the month. HHC has a large team working on putting the various required application submissions.

Ms. Bolus asked if the State could change the process in the future. Ms. Zurack stated that it is not likely that the State would change the process. In Year 1 there is $70 million for planning. The big dollar amount for the uses of the federal funds is $6.48 billion in performance payments. These are payments with similar logic that half to publics and the other half for the non-publics targeted for delivery services performed. The State is expecting to see the healthcare delivery system in NY change in many fundamental ways. One is to establish the concept of performing provider systems. There are systems that involve multiple healthcare entities getting together to collaborate to provide population base healthcare in their communities which can either be public or safety net provider systems. HHC has spent a lot time over the year explaining what the safety net definition should be. However, the definition has become very broad that allows for almost any hospital in NY to be considered a safety

net. Years ago, a safety net hospital was defined as providing 50% of care to Medicaid and the uninsured populations. In the current definition the threshold is much lower and includes Medicare.

Ms. Youssouf asked what the threshold is. Ms. Zurack stated that it is 35% but Medicare is also allowed as part of the count whereas in the past it was not and has created a scenario whereby very few hospitals are excluded. There is a methodology that the State is also putting forth, all hospitals must submit applications for those projects and form a performing provider systems and collaborate within and outside of the systems. It is anticipated that through this process there will be some positive outcomes.

Ms. Youssouf asked whether the other provider's community health systems, other provider hospitals, etc. were included. Ms. Brown stated that all of those were included in addition to nursing homes, federally qualified health centers (FQHC), physician groups, housing providers, etc.

Ms. Zurack stated that the performing provider systems objectives are to improve and transform their own system and work together with the objective to achieve reductions in unnecessary admissions and re-admissions, quality improvement in both clinical standards within the hospitals as well as population health standards. Additionally, it must involve a transformation that makes the hospitals' systems more integrated in sharing information and in sharing patients.

Ms. Youssouf asked if the organizations that collaborate with HHC would share in getting some of those funds. Ms. Zurack stated that it would depend. There are multiple ways HHC can approach the application. HHC's letter of intent is due Thursday, May 15, 2014. The IAAF is due May 30, 2014; planning grants are due June 16, 2014 and the ultimate applications are due December 17, 2014. As this indicates there is a lot of work that has to be done. The purpose of sharing this chart with the Committee is to provide an overview of the risk and the sources and uses of funding; the determination of how the funding will be split that will be a function of the quality scores that are received on the quality of the application and the topics that are selected.

Mrs. Bolus asked if the State would be counting the actual performance or the results. Ms. Zurack stated that it would be the results. The awards will be made after an assessment by an independent entity is completed and a quality score and topic score will be made to each system and will have a number of Medicaid lines associated. The sum of all those factors will determine the maximum grant that system is eligible for. The IGT for the public system is awarded $1 billion over the five years. The public system has to put up the match for its $1 billion plus the match for the safety net system. Essentially the way it will work is that the public system would need to put up a $2 billion match to get a $4 billion payment and then make another $1 billion payment to support the match of the safety net system. Reiterating the sequence of the process, the application is due December 17, 2014 and the awards will be made in January 2015 and the monies are scheduled to flow to the hospitals April 2015. There is a trigger that will start the flow of the monies in the first year that might be the submission of the plan. In the first year before the public hospitals receive its first payment, an IGT payment must be made to support both the hospital and the local share of the payment, an equivalent local share for a safety net hospital. In summary, if the public hospitals get a $1 billion and if the DSRIP formula was indicating the public hospitals were entitled to a $1 billion, the hospital must make a $2 billion

payment that will then be match with $2 billion in federal funds for a total of $4 billion of which the public hospital must return $1 billion to the State whereby the State will make another matching payment of $1 billion and make another $2 billion to the sister safety net hospital in the voluntary sector. The public would keep $3 billion of the $2 billion payment resulting in a net $1 billion payment for the public hospital.

Dr. Raju stated that the public hospital will get back its IGT share plus $1 billion.

Ms. Youssouf asked if HHC would need to have the $2 billion initially. Ms. Zurack stated that the $2 billion would be needed and what has to happen is that the State is aware of HHC's cash flow problem. Consequently, the $610 million is awarded to HHC for the UPL retroactive payment, the State will know the date of receipt for that payment to HHC. HHC will need to time its IGT within a three-day window in order to make the IGT. The State infrastructure for initiating that type of transaction is currently not in place. However, there is a $50 million budget for an administration program.

Mrs. Bolus asked if HHC's application is not approved would HHC lose its funds. Ms. Zurack stated that the money is not fronted without an approval. The application must be approved and the award sealed that meet the metrics.

Ms. Bolus added that it is a convoluted process that will only get HHC $1 billion.

Ms. Zurack stated that in other words, HHC would put up $2 billion and get a net of $1 billion.

Dr. Raju added that it would be in addition to what is put up and if HHC does not put the money up, it will not get the $1 billion. The $1 billion must be earned. It is no longer automatically given. Therefore, HHC has to compete with the other safety net hospitals in order to get its share. The funding must be upfront but no payments are made until the application is approved and the projects are equivalent to what was put in. If the approval is for $500 million then the payment would only be for that amount.

Ms. Zurack stated that the way this will appear is that HHC will have an additional expense of $3 billion with additional revenue of $4 billion for a net of $1 billion DSRIP payment.

Ms. Bolus raised concerns regarding the process that requires HHC to put the money upfront and the affect that would have on HHC's operations. Determining what would be put on hold while HHC is undergoing the process is of great concern. Ms. Zurack stated that HHC shares those concerns and that a request has been made to have the payment processed within 24 hours. However, the State is indicating a three-day turnaround.

Ms. Bolus commented that if there is no system in place, how would the State make that determination without a process in place.

Ms. Zurack stated that the State has set aside funding to get that process in place in order to manage the program.

Mr. Page asked where the budget for the $50 million would go. Ms. Zurack stated that it would be the State Department of Health (SDOH).

Mr. Rosen noted that the receipts and expenses will not occur in the same year.

Ms. Zurack stated that issue was raised with the State as well as the timing. In determining what HHC's maximum IGT would be, an analysis of the payments was done by Mr. Weinman's office and that amount totals, $600 million which would be HHC's maximum for IGT excluding the federal share without recycling other federal funds. In Year 3, the State has bunched a number of IGT payments and it does not match from year to year. However, the State has indicated that the issue has been addressed with CMS and is confident that it will work.

Dr. Raju stated that one of the issues besides fronting the $1 billion is that the entire program is contingent on the fact that the money for the IGT is on the table and the State cannot leverage to get the money back from the federal government. Therefore, it is in the best interest of the State to ensure that HHC has enough money to put up front in order to get the federal government matching funds. Again there is no defined infrastructure; however, the State has devised a plan that will quickly allow the State to meet the goal of getting those matching funds from the federal government. The success of the program is dependent upon this.

Ms. Youssouf asked if was a state or federal creation and whether it is only NY or country-wide. Ms. Zurack stated that it was a collaborative effort and that there are other waivers in other states that have elements of this but not all of the same variables.

Ms. Youssouf asked if there is a simpler way of achieving this process. Ms. Zurack stated that the only way would have required the State to put up the funding.

Dr. Raju stated that there are some simpler ways having been out of HHC and a couple of variables although the process is more complex in that it forces the SDOH to change the entire delivery system model given that it somewhat assures CMS that there is some collaboration between the various healthcare providers in NYS. Therefore, one way to force that collaboration is to have the matching money as an incentive. There are four principles involved in the collaboration. There are complex methodologies and no other State has as many varied players in the system.

Mr. Page asked if it turns out that one technical condition is unattainable who has the authorization to remove it, the State or CMS and whether those two entities realize that HHC could go "belly-up" because it is impossible to get through this process to get the money and it if it is decided that HHC should get the money who would have control over that action.

Ms. Zurack stated that the SDOH has shared with HHC the concept that if in the future the State needed more of the IAAF there might be the ability to take what might have been the DSRIP funding and modify it to be IAAF which might require a State plan amendment that would also require the approval of the federal government, CMS. In that scenario where there is a particular hospital that might go belly-up, public or safety net and there is an effort to save that hospital, with the approval of

CMS, NYSDOH could transfer monies from the DSRIP funding to the IAAF which is the cash flow emergency funding that would still involve the IGT.

Mr. Rosen added that the question is how a hospital would get the upfront money if it's going belly-up.

Ms. Zurack stated that the State's view the source of funding as either the hospital or the county. In the case of SUNY or the hospitals there is a little cushion in Westchester, Eerie, Nassau, NYC and SUNY and not solely on the backs of the individual hospitals. The matching funding for SUNY may not come from the three hospitals, University Hospital of Brooklyn, Stony Brook, and Syracuse but rather from SUNY.

Ms. Youssouf asked if there is a new administration at the State level will there be an opportunity to change the process.

Ms. Zurack stated that there would be but there would be a number of risks that could derail the process. There is the risk of it not being approved at the federal level by individuals other than those who approved the initial process; there is the risk of having to spend more than what this is worth but there is an opportunity for HHC to transform a very big, expensive, inefficient, non-collaborative, very non-patient centered healthcare system.

Mrs. Bolus added that there are a number of expenses that will become due soon that will affect HHC ability to come up with the upfront monies, contracts, etc. Additionally, it is difficult to find the funding when HHC has cut back substantially.

Ms. Zurack stated that it would be very difficult, the coordination, planning and financing. Mr. Rosen added that it was important not to lose sight of the goal which is to improve the healthcare system. Ms. Zurack added that the ultimate goal is to reduce the inpatient utilization and if HHC cannot increase its market share through its partnerships there will be an excess capacity of beds that will need to be addressed. The current reimbursement pays more for inpatient services relative to cost than it does for outpatient services. Therefore, the success could be an economic problem.

Ms. Youssouf asked if this is included in HHC's financial plan, strategically, given that there are some approved contracts totaling multiple millions such as IT would that be an area HHC would be reviewing.

Dr. Raju stated that while it is apparent that any transformation can be daunting; however, HHC cannot afford to lose market share. It would not be sustainable. There are a lot risks but HHC has to prepare for the transformation that is quickly moving forward and not being a participant in the process would not guarantee any financial stability. All of the concerns that have been raised are understandable; however, the Committee and the Board must be aware of these risks and the need for HHC to take them. HHC is a large system and trying to keep afloat in the years ahead will put HHC on the cutting edge of transformation. This is not unique to HHC but to hospitals across the country. HHC must do everything possible to keep its system intact by continuing to work at improving and managing its overall structure.

Ms. Zurack stated that through discussions with NYSDOH, HHC has raised the risk centered on the IGT transaction and have been assured by the SDOH that the State would be willing to protect HHC from that risk that would indemnify HHC in some way. However, the risk of potential revenue losses would not be included as part of that protection. HHC has submitted comments to the State regarding the documents that will achieve some of that in writing and HHC is awaiting a response. In terms of the Board there should be an urgency to get this request in writing for full disclosure as a protection in the future which is a major concern in terms of getting that in writing.

Ms. Brown added that there could be congressional hearings that target NYS getting $8 billion through this very complicated schema and would claim that it was an inappropriate use of the IGT funds. There is the optics and there is also the possibility that there is a new Congress, a new President, and a new administration that might conclude that CMS erred in its ways and where that would leave HHC is uncertain. The issue would be whether the City, HHC and the other publics would need to find money to return or does the State return the money. Therefore, that indemnification is critical for HHC.

Dr. Raju stated that the purpose of this discussion is that in the past the Board engaged subject matter experts with a group of people with the intent of achieving a particular goal. However, the future in the healthcare system that HHC is embarking on does not come with a playbook and there are no strategies. It is important for the Board to be involved in taking the risk with HHC given that there are no guarantees in this new scenario. The Corporation in conjunction with the Board must be flexible in the process of taking risks together as well as mitigating and advising on how to lessen the risk. This is the first of what is expected to be more updates on this process to the Committee and the Board.

Mr. Page added that in terms of the current direction of the healthcare industry, HHC cannot exist without being a part of the State and Federal governments going forward and this process appears to be where those two entities are attempting to go at this time. It is commendable that HHC is trying to do it as best as it can and make adjustments to reduce its risk and hopefully on the margin increase how HHC comes out in the process. It would appear that HHC does not have a choice and cannot decide to opt out of the process.

Mrs. Bolus agreeing with Mr. Page but added that meeting the requirement of the DSRIP funding was not the only thing on the table for HHC to address in terms of shuffling monies around to stay afloat with the current cash projection of only four day of COH. This is an extremely difficult and concerning matter.

Ms. Youssouf stated that this is a very difficult step for HHC to take and it will force some very difficult decisions to be made.

Mr. Rosen asked when HHC would expect to receive funding from this process.

Ms. Zurack stated that the first application is due May 30, 2014 for the IAAF and it is the intent of the State for HHC to get the first payment in June 2014 that would help the cash flow. At this time it is difficult to project when HHC can expect to receive payments until the initial application is approved.

As this process moves forward, HHC will keep the Committee and the Board informed of status. The report was concluded.

KEY INDICATORS/CASH RECEIPTS AND DISBURSEMENTS REPORTS **KRISTA OLSON/FRED COVINO**

Ms. Zurack informed the Committee that in the interest of time the reports were included in the package and would be tabled to allow the action items to go forward.

ACTION ITEM **JAY WEINMAN**

Authorizing the President of the New York City Health and Hospitals Corporation ("Corporation") to negotiate and execute an agreement with BSI Healthcare Audit Services LLC ("BSI") to provide the Corporation with payment recapture/recovery auditing services for Corporation's programs and activities, and to improve the Corporation's ability to detect, recover and prevent future improper payments. This contract is for a term of three (3) years with an option to extend for two additional one-year periods solely exercisable by the Corporation.

Mr. Weinman directed the Committee's attention to the presentation that would explain the need for a recovery vendor which is due primarily to HHC's inability to do this process in-house and the lack of the appropriate software that identifies and tracks paying patterns within the existing accounts payable to detect over payments. Currently, HHC spends approximately $1.5 billion annually and estimates that .25% is recoverable which would translate to $3.7 million annually. The vendor fee is based on a contingency amount and if no recoveries are made there is no payment or fee expended. There are over twenty vendors that do this type of work. Through the issuance of an RFEI, HHC received five proposals. BSI was selected by the selection committee as the lowest priced vendor and the quality of work. BSI is a $5 million professional consulting firm with twenty three years of experience in this area. BSI has provided these services to healthcare clients ranging from 100 to over 1,000 beds per site, including Kaiser Permanente, Fairview Health Services, BJC Health Care and NY Medical Center. As per BSI gross savings from recent clients range from$1.9 million to $8.5 million.

Ms. Youssouf asked if the purpose of engaging this service is to avoid a repeat of the problem going forward.

Mr. Weinman stated that BSI will provide reports throughout the process that will keep HHC informed of the problems and how and what should be done to avoid a repeat going forward.

Ms. Youssouf asked if HHC's internal audits was included in the process. Mr. Weinman stated that internal audits were not involved but had done routing checks of HHC's accounts payable and have identified some duplicate payments in their sample.

Mr. Martin added that internal audits supports this contract as a way of recouping monies.

Ms. Youssouf asked if in the future BSI and internal audits could interface in this process.

Ms. Zurack stated that Finance will arrange to have that done and perhaps do a presentation at the Audit Committee on this process and the results as it progresses.

Mr. Page asked if HHC should develop the capacity in-house as opposed to it being contracted out or is it practical as something HHC is moving towards.

Ms. Zurack stated that insofar as the consultant brings the capacity to identify problems that is a technology capacity that HHC would not need to develop in-house. It is anticipated that HHC will be able to pinpoint the source of the problem that can be corrected through a change in procedures. Therefore, the feedback must include interaction with internal audits which is important in the process.

The resolution was approved for the full Board's consideration.

ACTION ITEM **JOSEPH QUINONES**

Authorizing the President to negotiate and execute a contract extension between the New York City Health and Hospitals Corporation ("HHC" or the "Corporation") and Base Tactical Disaster Recovery, Inc. ("Base Tactical") to provide expert consulting services for disaster recovery, project management, and filing claims for reimbursement from the Federal Emergency Management Agency ("FEMA") for expenses incurred by the Corporation in connection with damages caused by Super-storm Sandy. The extension will be for a term of 12 months commencing August 1, 2014 through July 31, 2015,with one option to extend for an additional 12 months exercisable solely by the Corporation for an amount not to exceed $2,590,600.

Mr. Quinones introduced Mr. Levy, President, Base Tactical (BT) who would take the Committee through a presentation outlining the need for the extension and the status of the FEMA process.

Mr. Rosen asked if it was an extension of a new contract. Mr. Quinones stated that it is an extension of an existing contract that was approved by Board in January 2013.

Mr. Levy stated that BT in conjunction with HHC is making progress in response to the recovery process. The key at this time is to have the permanent or Category E obligated by FEMA and the development of the required submission for the big project which is the bulk of the money that includes the hardening of the facilities as the mitigation 404 and 406. Those proposals have been made and HHC administrative team went to Washington on April 11, 2014 whereby a presentation to FEMA was done and the response was favorable. Going forward it is expected that some will be done this summer and fall in order to protect the hospitals from future storms as quickly as possible. At each of the larger hospitals there are some major projects for significant improvements that require the approval of FEMA ranging from flood walls to flood gates to also proposing a new clinical service building at Coney Island hospital. In the normal course without FEMA there are seven areas HHC's administrative staff would work on in a normal capital project. In the FEMA claim's processing there are seven additional steps that are added to the normal capital process which doubles the process of producing a construction project. The FEMA procedure ultimately slows down the process.

Consequently, HHC has asked Base Tactical (BT) to provide experts who are familiar with the components of the FEMA process so as to keep the project moving given that there is a lot of work involved going forward in order to meet the FEMA requirements. Finally, it is anticipated that by the end of the year HHC will have a commitment from FEMA for the big projects, the hazardous mitigation projects as well as the obligation on the permanent work. The permanent work is approximately $414 million that is being requested from FEMA based on monies spent to-date and projected spending. HHC is asking FEMA and NYC on 404 mitigation which is State supported mitigation for $411 million and $974 million has been requested for hazardous mitigation which is primarily for Bellevue and Coney Island and the two programs for Coler and Metropolitan hospitals are currently being developed by BT's engineers.

Mr. Rosen asked if HHC has received any funding from FEMA and whether HHC has to go through the City or applies on its own. Mr. Covino stated that to-date HHC has received $65 million and an additional $4 million for capital projects through the City.

Ms. Zurack stated that HHC must go through the City as a sub-applicant.

Mr. Rosen asked if HHC were to get all of what has been requested how much would it be.

Mr. Levy responded that it would be extremely optimistic but the total amount is $1.5 billion.

The resolution was approved for the full Board's consideration.

INFORMATION ITEM **KRISTA OLSON**
PAYOR MIX REPORTS, INPATIENT, ADULT AND PEDIATRICS

Ms. Olson brought to the attention of the Committee one of the major changes in the payor mix since the last reported period, three months ago which was in the self-pay uninsured population. In the prior quarter there was a slight increase in that area relative to the prior year. The increase was due in part to the Exchanges which as reflected in the current quarter has declined to the same level as the previous year for the same period. The shift in the uninsured/self-pay went directly into the Medicaid total. There were no other major changes in comparison to the prior year in the inpatient area. On the outpatient side, in the adult payor mix there were some minor changes in the total Medicaid visits increased slightly and the fee-for-service managed care also increased slightly due to a shift from the uninsured. In the outpatient pediatrics payor mix there were some minor changes, basically shift within the various payors in comparison to the last reported period. The reporting was concluded.

Ms. Youssouf asked if the uninsured total is the same as the self-pay. Ms. Olson stated that it is a combination of both, self-pay and HHC Options.

Ms. Zurack added that HHC Options includes those patients who are fee-scaled and is tracked separately but are included in the uninsured count. Therefore the self-pay and uninsured are one in the same.

INFORMATION ITEM **FRED COVINO**
PS KEY INDICATORS QUARTERLY REPORT

Mr. Covino reported that since 2010, HHC has reduced its headcount by 3,450 FTEs with an annual saving of $225 million including fringe benefits increased to $350 million. Overall as noted on the report, there has been an increase in overtime, nurse registry and allowance. The costs this year have increased from 2010 to approximately $38 million including fringe benefits to $54 million on a net basis the saving have decreased from $350 million to $295 million. Through March 2014 expenses were $12.5 million greater than budget. The bulk of that increase was attributable to Goldwater Hospital which included the carrying cost for those employees who were transferred to other facilities within HHC and the overtime cost associated with the closing of that facility in addition to the opening of the new facility, Hank J. Carter Nursing Facility. The remaining increase against the budget included allowances and overtime. FTES by facility increased by nine corporate-wide with some increases in central office due to the transfer of FTEs relative to the centralization and consolidation of procurement and EEO divisions up by 62 FTES and an increase of 26.5 FTEs in Enterprise Information Technology (EIT) due to the conversion of consultants. As per HHC's budget plan, FTEs are projected to increase by 250. However, to-date a number of those new hires are yet to materialize; however, there has been an increase in allowances.

Ms. Youssouf asked for clarification of the conversion of the consultants in terms of the projected savings whether those costs were included in the savings.

Mr. Covino stated that the savings did not include the conversion of the consultants as part of EIT.

Ms. Zurack interjected that Ms. Youssouf was referring to the staffing at Crothall and the management fees. Some of the reductions in staffing were achieved through the outsourcing of the management services for environmental services and plant maintenance to Crothall, JCI and BCL contracts. However, it is not clear what percentage is attributable to those initiatives.

Mr. Covino stated that there has been very few reductions in staffing given that the only outsourcing was the management of those areas.

Ms. Zurack stated that there were some additional costs to support the management of those contractors. Insofar, as that relationship to the reduction in costs could be offset.

Mr. Covino stated that it was not included in those savings. Ms. Zurack stated that while it may not be a major factor, going forward that data can be reflected in the reporting.

Mr. Covino added that going forward the reporting will be adjusted to reflect that request. Returning to the reporting, FTEs changes by major category showed that there was an increase of 175 FTEs in nurses and an increase in managers and technicians, while clericals, environmental/hotel and aides and orderlies decreased. Overtime against the budget was $4.3 million over of which $3.4 million was at Coler/Goldwater and Hank Carter due to the transitioning of services from Goldwater to the new

facility, Hank Carter. Overtime expenses increased at Bellevue by $2 million due to the preparation for JCAHO.

Ms. Youssouf asked how the preparation for JCAHO related to the increase in overtime given that the facility should already be prepared for an unannounced survey. Mr. Covino stated that it relates to the facility's preparedness for the survey. Returning to the report, overtime comparison to the prior year showed a net increase of $4.4 million; $1.3 million in nursing, .5 million in plant maintenance and all other was up by $2.5 million due to patient care tech/associates and nurse aides. Nurse registry was up by $8.2 million compared to last year. At least half of that increase was at Harlem Hospital due to the plan of correction for citations from CMA. Other facilities, Bellevue was up by $2.3 million due to staff shortages in nursing. Metropolitan was up by $1.2 million due to an increase in workload as a result of the closure of Bellevue due to the storm. Kings County was up by $1 million due to a backlog in payments to nurse registry that were paid. Queens was up by $800,000 due to vacancies and new and expanded programs. Allowances/hourly increased by $10.3 million that was spread across the system due to the usage of hourly staff to replace temporary staff.

Ms. Youssouf asked what was included in the temporary staff. Mr. Covino stated that Queens used temporary staff for nurses instead of using temp agency services. The facility used hourly staff as vacancies were being filled and was also consistent at Lincoln, Elmhurst and Kings County hospitals. The reporting was concluded.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 10:25 a.m.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS

KEY INDICATORS
FISCAL YEAR 2014 UTILIZATION

Year to Date
April 2014

NETWORKS	UTILIZATION						AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	VISITS			DISCHARGES/DAYS						
	FY 14	FY 13	VAR %	FY 14	FY 13	VAR %	ACTUAL	EXPECTED	FY 14	FY 13
North Bronx										
Jacobi	354,188	377,376	-6.1%	16,440	15,395	6.8%	5.7	6.0	0.9995	1.0657
North Central Bronx	166,490	185,469	-10.2%	3,660	6,477	-43.5%	5.7	6.0	0.8937	0.7200
Generations +										
Harlem	272,462	258,266	5.5%	9,143	9,677	-5.5%	5.4	5.8	0.9508	0.9277
Lincoln	457,248	466,633	-2.0%	19,963	19,328	3.3%	4.7	5.4	0.8371	0.8706
Belvis DTC	44,386	48,043	-7.6%							
Morrisania DTC	68,415	68,086	0.5%							
Renaissance	39,773	48,223	-17.5%							
South Manhattan										
Bellevue	481,300	400,951	20.0%	19,122	13,084	46.1%	6.6	6.3	1.1061	1.0807
Metropolitan	325,401	345,763	-5.9%	9,312	10,514	-11.4%	4.6	5.2	0.7697	0.7796
Coler				229,949	179,349	28.2%				
Goldwater/H.J. Carter				95,791	235,850	-59.4%				
Gouverneur - NF				42,000	41,492	1.2%				
Gouverneur - DTC	222,687	206,988	7.6%							
North Central Brooklyn										
Kings County	570,356	594,486	-4.1%	18,736	20,465	-8.4%	6.5	6.1	0.9864	0.9500
Woodhull	406,113	401,950	1.0%	10,709	11,577	-7.5%	5.0	5.0	0.7954	0.8105
McKinney				94,815	94,632	0.2%				
Cumberland DTC	70,194	75,119	-6.6%							
East New York	60,781	63,139	-3.7%							
Southern Brooklyn / S I										
Coney Island	283,573	228,467	24.1%	11,717	7,561	55.0%	6.8	6.3	1.0243	1.0185
Seaview				88,314	90,345	-2.2%				
Queens										
Elmhurst	517,114	542,289	-4.6%	17,707	19,699	-10.1%	5.5	5.3	0.8935	0.9070
Queens	339,974	346,660	-1.9%	10,081	10,683	-5.6%	5.7	5.3	0.8555	0.8701
Discharges/CMI-- All Acutes				146,590	144,460	1.5%			0.9326	0.9204
Visits-- All D&TCs & Acutes	4,680,455	4,657,908	0.5%							
Days-- All SNFs				550,869	641,668	-14.2%				

Notes:

Utilization

Acute: discharges exclude psych and rehab; reimbursable visits include clinics, emergency department and ambulatory surgery

D&TC: reimbursable visits

LTC: SNF and Acute days

Average Length of Stay

Actual: discharges divided by days; excludes one day stays

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

All Payor CMI

Acute discharges are grouped using the 2013 New York State APR-DRGs for FY 13 and FY 14 beginning December 2013.

FY 13 reflects the impact of the temporary closures and suspension of operations at Bellevue and Coney Island hospitals as a result of Hurricane Sandy (Oct 2012)

As of April 10, 2014, all services at Coney Island have been fully restored.

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KEY INDICATORS

FISCAL YEAR 2014 BUDGET PERFORMANCE ($s in 000s)

Year to Date April 2014

NETWORKS	FTE's VS 6/15/13	RECEIPTS actual	RECEIPTS better / (worse)	DISBURSEMENTS actual	DISBURSEMENTS better / (worse)	BUDGET VARIANCE better / (worse)	
North Bronx							
Jacobi	(27.5)	$ 447,071	$ (1,872)	$ 447,787	$ 1,294	$ (577)	-0.1%
North Central Bronx	(26.0)	144,096	(20,628)	143,340	25,331	4,702	1.4%
	(53.5)	$ 591,167	$ (22,500)	$ 591,127	$ 26,625	$ 4,125	0.3%
Generations +							
Harlem	18.5	$ 281,743	$ (14,794)	$ 279,206	$ (6,069)	$ (20,863)	-3.7%
Lincoln	22.0	423,720	12,408	392,722	489	12,897	1.6%
Belvis DTC	(3.0)	13,751	(867)	12,740	2,967	2,100	6.9%
Morrisania DTC	(4.0)	20,567	911	21,075	3,417	4,328	9.8%
Renaissance	(5.0)	12,211	(2,339)	17,331	392	(1,947)	-6.0%
	28.5	$ 751,992	$ (4,681)	$ 723,075	$ 1,197	$ (3,484)	-0.2%
South Manhattan							
Bellevue	6.5	$ 554,043	$ (30,085)	$ 599,859	$ (13,895)	$ (43,980)	-3.8%
Metropolitan	(40.5)	255,278	(9,428)	244,693	14,205	4,777	0.9%
Coler	39.5	47,130	(13,468)	111,054	(17,954)	(31,422)	-20.4%
Goldwater/H.J. Carter	(364.0)	53,920	(17,791)	122,471	(35,281)	(53,072)	-33.4%
Gouverneur	43.5	55,225	(5,185)	73,227	1,466	(3,719)	-2.8%
	(315.0)	$ 965,597	$ (75,957)	$ 1,151,305	$ (51,459)	$ (127,415)	-6.0%
North Central Brooklyn							
Kings County	39.5	$ 596,093	$ (14,172)	$ 559,845	$ 5,006	$ (9,166)	-0.8%
Woodhull	53.0	302,744	(32,578)	329,098	(13,171)	(45,749)	-7.0%
McKinney	8.0	26,674	(1,361)	37,084	(645)	(2,006)	-3.1%
Cumberland DTC	(7.0)	18,069	(4,802)	25,683	3,124	(1,678)	-3.2%
East New York	6.0	17,271	(2,154)	19,802	855	(1,299)	-3.2%
	99.5	$ 960,850	$ (55,067)	$ 971,513	$ (4,831)	$ (59,899)	-3.0%
Southern Brooklyn/SI							
Coney Island	97.0	$ 239,641	$ (33,569)	$ 297,237	$ (3,570)	$ (37,140)	-6.6%
Seaview	(6.0)	31,249	3,512	43,052	(928)	2,584	3.7%
	91.0	$ 270,890	$ (30,058)	$ 340,289	$ (4,498)	$ (34,556)	-5.4%
Queens							
Elmhurst	2.5	$ 465,969	$ (7,051)	$ 446,945	$ 8,786	$ 1,735	0.2%
Queens	5.0	310,447	3,578	297,921	(8,808)	(5,229)	-0.9%
	7.5	$ 776,416	$ (3,472)	$ 744,866	$ (22)	$ (3,494)	-0.2%
NETWORKS TOTAL	**(142.0)**	**$ 4,316,912**	**$ (191,736)**	**$ 4,522,174**	**$ (32,988)**	**$ (224,723)**	**-2.5%**
Central Office	60.0	233,530	(719)	198,981	8,786	8,067	1.8%
HHC Health & Home Care	9.0	11,126	(12,865)	30,193	(5,366)	(18,231)	-37.3%
Enterprise IT	23.5	53,650	577	149,108	6,602	7,179	3.4%
GRAND TOTAL	**(49.5)**	**$ 4,615,217**	**$ (204,743)**	**$ 4,900,457**	**$ (22,966)**	**$ (227,709)**	**-2.3%**

Notes:

FY 13 reflects the impact of the temporary closures and suspension of operations at Bellevue and Coney Island hospitals as a result of Hurricane Sandy (Oct 2012)

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Henry J. Carter Specialty Hospital and Nursing Facility (HJC) began receiving patients on November 24, 2013; the Goldwater campus relocated its last patient to HJC on November 25, 2013.

New York City Health & Hospitals Corporation
Cash Receipts and Disbursements (CRD)
Fiscal Year 2014 vs Fiscal Year 2013 (in 000's)
TOTAL CORPORATION

	Month of April 2014			Fiscal Year To Date April 2014		
	actual 2014	actual 2013	better / (worse)	actual 2014	actual 2013	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 66,355	$ 65,676	$ 679	$ 693,593	$ 707,919	$ (14,325)
Medicaid Managed Care	53,007	51,036	1,971	533,072	514,470	18,602
Medicare	42,432	30,309	12,122	457,627	416,440	41,187
Medicare Managed Care	31,707	22,286	9,421	263,726	188,862	74,865
Other	21,004	19,997	1,007	192,499	177,894	14,605
Total Inpatient	$ 214,505	$ 189,304	$ 25,201	$ 2,140,518	$ 2,005,584	$ 134,933
Outpatient						
Medicaid Fee for Service	$ 12,071	$ 14,615	$ (2,544)	$ 152,047	$ 141,763	$ 10,284
Medicaid Managed Care	32,634	39,619	(6,985)	461,598	345,580	116,018
Medicare	4,823	4,429	395	42,972	45,905	(2,934)
Medicare Managed Care	6,803	12,646	(5,843)	81,575	80,092	1,484
Other	12,602	12,943	(341)	143,278	120,551	22,727
Total Outpatient	$ 68,933	$ 84,251	$ (15,318)	$ 881,470	$ 733,891	$ 147,580
All Other						
Pools	$ 87,535	$ 95,432	$ (7,898)	$ 422,852	$ 429,604	$ (6,752)
DSH / UPL	-	-	0	876,600	878,435	(1,835)
Grants, Intracity, Tax Levy	10,216	30,874	(20,657)	196,568	297,564	(100,996)
Appeals & Settlements	1,528	(4,780)	6,308	45,414	35,082	10,333
Misc / Capital Reimb	5,272	4,383	890	51,795	64,695	(12,899)
Total All Other	$ 104,551	$ 125,908	$ (21,357)	$ 1,593,229	$ 1,705,379	$ (112,149)
Total Cash Receipts	**$ 387,988**	**$ 399,463**	**$ (11,475)**	**$ 4,615,217**	**$ 4,444,853**	**$ 170,364**
Cash Disbursements						
PS	$ 187,516	$ 184,239	$ (3,277)	$ 2,051,136	$ 2,052,166	$ 1,030
Fringe Benefits	71,957	65,166	(6,791)	898,785	611,525	(287,261)
OTPS	115,539	108,497	(7,042)	1,118,217	1,096,577	(21,640)
City Payments	-	-	0	19,403	141,363	121,960
Affiliation	73,135	80,890	7,755	749,486	769,950	20,464
HHC Bonds Debt	7,178	4,024	(3,154)	63,429	85,213	21,784
Total Cash Disbursements	**$ 455,325**	**$ 442,816**	**$ (12,509)**	**$ 4,900,457**	**$ 4,756,794**	**$ (143,663)**
Receipts over/(under) Disbursements	**$ (67,337)**	**$ (43,353)**	**$ (23,984)**	**$ (285,239)**	**$ (311,941)**	**$ 26,701**

Notes:
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New York City Health & Hospitals Corporation
Actual vs. Budget Report
Fiscal Year 2014 (in 000's)
TOTAL CORPORATION

	Month of April 2014			Fiscal Year To Date April 2014		
	actual 2014	budget 2014	better / (worse)	actual 2014	budget 2014	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 66,355	$ 85,852	$ (19,497)	$ 693,593	$ 843,648	$ (150,055)
Medicaid Managed Care	53,007	59,477	(6,470)	533,072	583,373	(50,301)
Medicare	42,432	36,981	5,451	457,627	425,758	31,869
Medicare Managed Care	31,707	22,244	9,463	263,726	209,336	54,390
Other	21,004	18,827	2,177	192,499	194,123	(1,624)
Total Inpatient	$ 214,505	$ 223,381	$ (8,877)	$ 2,140,518	$ 2,256,238	$ (115,720)
Outpatient						
Medicaid Fee for Service	$ 12,071	$ 17,575	$ (5,504)	$ 152,047	$ 198,077	$ (46,030)
Medicaid Managed Care	32,634	40,215	(7,581)	461,598	473,149	(11,551)
Medicare	4,823	5,874	(1,051)	42,972	63,864	(20,892)
Medicare Managed Care	6,803	7,163	(360)	81,575	82,749	(1,174)
Other	12,602	13,911	(1,309)	143,278	154,039	(10,761)
Total Outpatient	$ 68,933	$ 84,738	$ (15,806)	$ 881,470	$ 971,877	$ (90,407)
All Other						
Pools	$ 87,535	$ 87,342	$ 192	$ 422,852	$ 425,647	$ (2,795)
DSH / UPL	-	-	0	876,600	876,600	(0)
Grants, Intracity, Tax Levy	10,216	12,319	(2,103)	196,568	193,806	2,762
Appeals & Settlements	1,528	(1,867)	3,394	45,414	42,134	3,280
Misc / Capital Reimb	5,272	4,886	386	51,795	53,658	(1,863)
Total All Other	$ 104,551	$ 102,680	$ 1,870	$ 1,593,229	$ 1,591,845	$ 1,385
Total Cash Receipts	**$ 387,988**	**$ 410,800**	**$ (22,812)**	**$ 4,615,217**	**$ 4,819,960**	**$ (204,743)**
Cash Disbursements						
PS	$ 187,516	$ 187,452	$ (64)	$ 2,051,136	$ 2,038,523	$ (12,613)
Fringe Benefits	71,957	69,769	(2,188)	898,785	903,224	4,439
OTPS	115,539	115,544	5	1,118,217	1,101,102	(17,115)
City Payments	-	-	0	19,403	19,403	(0)
Affiliation	73,135	72,810	(325)	749,486	749,130	(356)
HHC Bonds Debt	7,178	6,961	(217)	63,429	66,108	2,679
Total Cash Disbursements	**$ 455,325**	**$ 452,536**	**$ (2,789)**	**$ 4,900,457**	**$ 4,877,491**	**$ (22,966)**
Receipts over/(under) Disbursements	**$ (67,337)**	**$ (41,736)**	**$ (25,601)**	**$ (285,239)**	**$ (57,531)**	**$ (227,709)**

Notes:
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INFORMATION ITEM #1

QUARTERLY STATEMENT OF REVENUE & EXPENSES

AS OF MARCH 31, 2014 AND 2013

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of the City of New York)

Statement of Revenue and Expenses

Periods ended March 31, 2014 and 2013

(in thousands)

	HHC		MetroPlus		Inter-Company Elimination Entries		Totals		
	2014	2013	2014	2013	2014	2013	2014	2013	Variance
Operating revenues:									
Net patient service revenue	$ 4,474,083	3,792,919	-	-	(575,323) (1)	(566,625) (1)	3,898,760	3,226,294	672,466
Appropriations from (remittances to) the City, net	3,690	(16,576)	-	-	-	-	3,690	(16,576)	20,266
Premium revenue	-	-	1,725,810	1,672,052	(15,153) (2)	(12,492) (2)	1,710,657	1,659,560	51,097
Grants revenue	249,877	308,098	-	-	-	-	249,877	308,098	(58,221)
Other revenue	35,555	30,385	3	4	-	-	35,558	30,389	5,169
Total operating revenues	4,763,205	4,114,826	1,725,813	1,672,056	(590,476)	(579,117)	5,898,542	5,207,765	690,777
Operating expenses:									
Personal services	1,860,553	1,835,304	43,060	41,356	-	-	1,903,613	1,876,660	26,953
Other than personal services	1,116,226	1,083,705	1,595,195	1,547,556	(575,323) (1)	(566,625) (1)	2,136,098	2,064,636	71,462
Fringe benefits and employer payroll taxes	910,471	869,721	19,529	16,752	(15,153) (2)	(12,492) (2)	914,847	873,981	40,866
Postemployment benefits, other than pension	231,145	293,240	5,444	5,470	-	-	236,589	298,710	(62,121)
Affiliation contracted services	702,132	678,005	-	-	-	-	702,132	678,005	24,127
Depreciation	194,256	189,342	1,959	1,638	-	-	196,215	190,980	5,235
Total operating expenses	5,014,783	4,949,317	1,665,187	1,612,772	(590,476)	(579,117)	6,089,494	5,982,972	106,522
Operating income (loss)	(251,578)	(834,491)	60,626	59,284	-	-	(190,952)	(775,207)	584,255
Nonoperating revenues (expenses):									
Investment income	1,167	2,292	1,383	1,055	-	-	2,550	3,347	(797)
Interest expense	(85,039)	(72,461)	-	-	-	-	(85,039)	(72,461)	(12,578)
Noncapital contributions	550	1,680	-	-	-	-	550	1,680	(1,130)
Total nonoperating revenues (expenses)	(83,322)	(68,489)	1,383	1,055	-	-	(81,939)	(67,434)	(14,505)
Income (Loss)	$ (334,900)	(902,980)	62,009	60,339	-	-	(272,891)	(842,641)	569,750

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

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

INFORMATION ITEM #2

Presentation will be forwarded under separate cover

NYSDOH/EXCHANGES PRESENTATION

NY State of Health

the Official Health Plan Marketplace

Danielle Holahan

Health and Hospitals Corporation
June 10, 2014

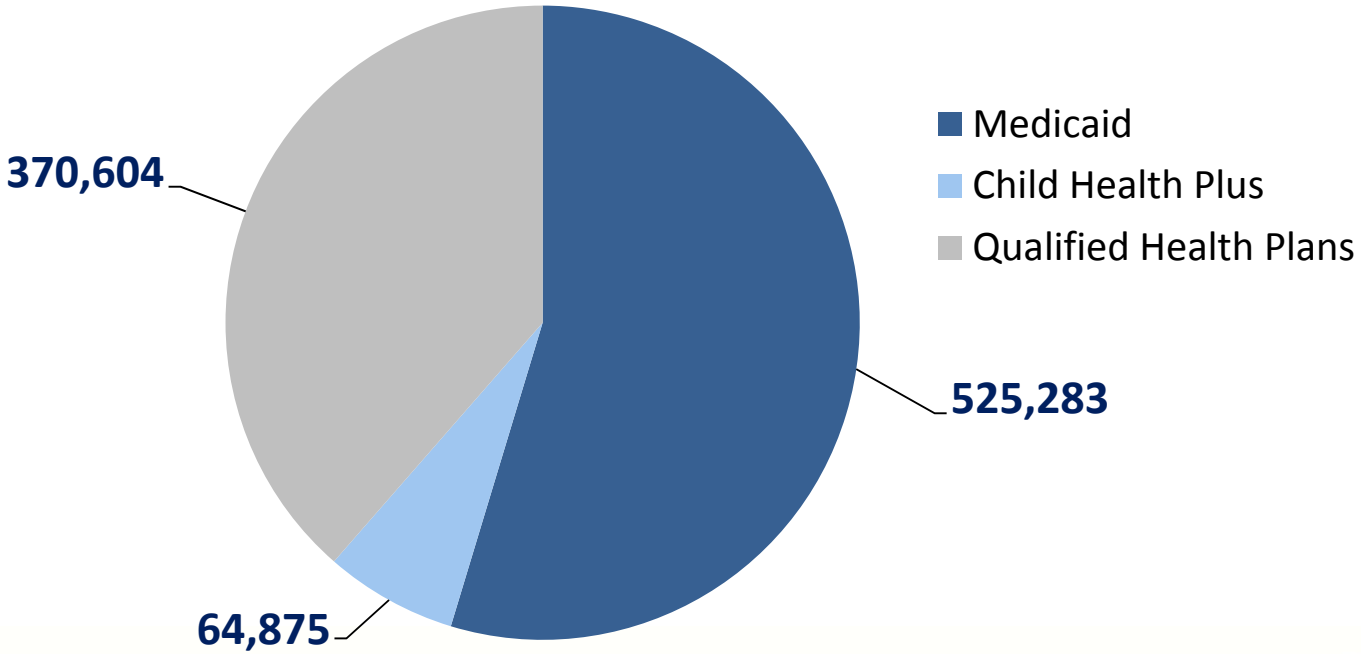
NY State of Health Highlights

- **Ease of Application:** Apply on-line, by phone, with an in-person assistor, or by mail
- **Affordable:** Health plans offered through NY State of Health are on average 53 percent less expensive than coverage New Yorkers purchased directly last year – before tax credits
- **Comprehensive**: All plans include ten essential health benefits
- **Choice of Private Health Plan:** Sixteen health insurers and ten stand-alone dental plans

NY State of Health Enrollment

(as of April 15, 2014)

Individual Marketplace



Total Enrollment: 960,762

NY State of Health Volume Statistics

- Thousands of people enroll in coverage each day
  - 134,000 enrolled in final week of March
  - Highest daily enrollment on March 31 at 39,000 followed by December 23 at 26,000 enrollments
- Customer Service Center has answered 1.2 million calls since inception
- More than 8,800 trained, certified assistors are available to help New Yorkers complete applications in person

NY State of Health Enrollees

- Over 80 percent of those who enrolled through the Marketplace reported that they were uninsured at the time of application
- Over 70 percent of those who enrolled in a Qualified Health Plan were eligible for financial assistance
- Qualified Health Plan enrollment in:
  - All counties of the state
  - All metal levels
  - All age groups

March 31 Enrollment Deadline Activities

- Launched a targeted outreach and advertising effort focused on Latinos and young adults
- Augmented our customer service center staff
- Emailed New Yorkers who completed applications but did not select their health plan to remind them of the March 31 deadline
- Launched a new and improved tax credit and premium calculator making it even easier for consumers to estimate their tax credits

A Few Lessons Learned

- "One-stop" eligibility and enrollment is more efficient and more consumer-friendly
- Need to be ready to respond quickly
- IT systems needs to be flexible and agile
- Call volume will be higher than expected and it will increase significantly on key days

A Few Lessons Learned (cont.)

- Consumers want a range of application channels
- Plan selection is a complex, highly individualized decision
- Continuous improvement is a daily task

Right Now

- Enrollment in Medicaid, Child Health Plus is open
- Enrollment in Qualified Health Plans ended on April 15, 2014
  - Only individuals who qualify for a Special Enrollment Period can enroll in the remainder of 2014
  - Next open enrollment period: Nov 15, 2014 to Feb 15, 2015
- SHOP is open for enrollment

Looking Ahead

- 2015 Health Plan Invitation
- Demographic Report for 1st Open Enrollment
- Refresher training for application assistors
- Administrative renewal process for 2015
- Outreach and Advertising:
  - Small Business Marketplace
  - Fall 2014 open enrollment campaign
  - Regroup on grassroots outreach/events
- Continued website development and improvements